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TABLE OF CONTENTS

	PAGE
THE PRACTICING PHYSICIAN AND ACCIDENT PREVENTION—The 12th Annual Charles V. Chapin Oration— <i>George M. Wheatley, M.D.</i>	429
WHY MEDICAL EXPERTS DISAGREE, <i>John E. Donley, M.D.</i>	436
INTUSSUSCEPTION, RETROGRADE (ILEO-ILEAL) WITH ASEPTIC STRANGULATION NECROSIS, <i>Eske Windsberg, M.D., F.A.C.S.</i>	439
DOCTORS AND HOSPITALS, <i>Philip D. Bonnet, M.D.</i>	442
LOW BACK PAIN, <i>Edward H. Crosby, M.D.</i>	450

EDITORIALS

Malpractice is Your Problem.....	446
Doctors and Hospitals	447
The Osteopathic Issue	447
Interprofessional Relations	447
Midsummer Madness	448

DEPARTMENTS

On the Medical Library Bookshelves	466
Book Reviews	468
Professional Graduate Nurses' Fees.....	469
Training in Child Psychiatry at the Bradley Home.....	469
Annual Reports, R. I. Medical Society.....	470

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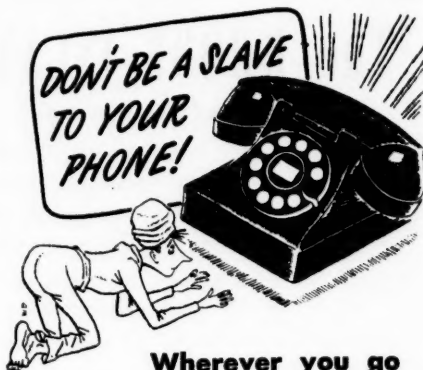
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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXVI

AUGUST, 1953

NO. 8

THE PRACTICING PHYSICIAN AND ACCIDENT PREVENTION* — THE TWELFTH ANNUAL CHARLES V. CHAPIN ORATION —

GEORGE M. WHEATLEY, M.D., M.P.H.

The Author, George M. Wheatley, M.D., of New York City. Third Vice President, The Metropolitan Life Insurance Company; Chairman, Accident Prevention Committee, American Academy of Pediatrics.

"ACCIDENTS are more preventable than disease." Charles Chapin said that nearly twenty-nine years ago. It is entirely appropriate that your committee should choose accident prevention as the subject for this twelfth Chapin Oration. Nearly three decades ago, Doctor Chapin was calling attention to the accident problem. This is further evidence of the vision and public health leadership of the man whose memory is respected this evening. I am greatly privileged and also awed by the responsibility you have given me. The Rhode Island Medical Society honors itself in this annual tribute to the great health officer of the City of Providence. No finer method could be chosen to demonstrate the interrelationship of the practice of medicine and the practice of public health than through this annual affair. In selecting the subject of accident prevention, you have chosen to highlight a challenging public health problem and one in which I believe every practicing physician has some responsibility. If thirty years ago the practicing physician had responsibility, as a partner of the health officer, to prevent disease, today the practitioner, I hope to show, has a similar role in the prevention of accidents.

We are all aware of the remarkable achievements in disease prevention in the past several decades. Vaccines and antibiotics have made preventive medicine a reality in everyday practice. As a result, most infectious diseases can be controlled and some have been virtually eliminated as major causes of death. With these medical triumphs, new health problems have emerged to command the attention of the medical investigator, the health officer and the practicing physician. One of staggering proportions is accidental trauma.

*Presented at the 142nd Annual Meeting of the Rhode Island Medical Society, at Providence, R. I., May 6, 1953.

In 1952, more than 96,000 Americans lost their lives by accidents. Only cardiovascular disease and cancer deaths now exceed those due to unexpected injury. Accidents are the leading cause of death from ages 1 to 25; second to heart disease in the broad age group 25 to 44; and fifth among persons 45 and over. In contrast to cancer or circulatory disease, accidents too frequently take the lives of many in childhood or in their prime. Or to express it in another way, fatal accidents cut off more years from the working life of the American people today than any other single cause of death.

The Menace of the Machine

An important factor in the accident problem is the machine. Last year, 38,000 Americans were killed and 1,350,000 were injured in auto accidents. Farm accidents due to increasing mechanization of the farm are all too common. Industry has made great progress in protecting man from the hazard of machinery. Nevertheless, last year 16,500 workers lost their lives from accidents on the job. The home, almost as mechanized as a factory, especially with the growing popularity of power-tools for home workshops, is nearly as dangerous as the highway. In 1952, 27,500 persons died in home accidents. The machine, a proud symbol of our modern age, is now almost as great an environmental hazard to man as bacteria.

Like the visible portion of a towering iceberg, these morbid statistics, while they arrest attention, are but a small part of the total picture. They reveal a fraction of the total social and economic loss. For example, the value of property destroyed and damaged by traffic accidents last year is estimated at \$1,500,000,000. All costs including medical expenses were \$3,600,000,000. For every fatal accident, it is estimated there are at least 100 serious enough to cause disability for a day or more. If we consider all battle casualties in World War II, the number of those killed, wounded, and taken prisoner combined was about one-eighth of the accidental injuries last year in the United States.

These facts mean that treatment of accidental

continued on next page

trauma is an important and growing part of a physician's practice. But until recently, the prevention of injuries has not occupied the attention of any large segment of the medical profession. Prevention has been left to safety organizations. The National Safety Council and its state and local affiliations are doing a fine job, especially in public education, in industry and through the schools, farm organizations and highway safety programs. But the National Safety Council has been among the first to indicate that this country cannot have a comprehensive accident prevention program without the active participation of organized medicine and public health agencies.

As physicians, because you witness daily the brutal and tragic results of accidents, you must also see the need for more adequate study and control of this waste of human and material resources. By your training as well as experience, you can, if you will, make important contributions to accident prevention. Prevention must be based on adequate knowledge. Accident research is still in a primitive stage. Knowledge about the cause of accidents is somewhat comparable to our knowledge of disease etiology a century ago. Then, diseases were identifiable, but exactly why and how an individual became ill and died was largely unknown. Today, too little is known about the circumstances which lead up to and precipitate accidents. Even less is known about the health, personality and behavior of those who have accidents.

This need to focus on the individual is one of the most important reasons for physicians to participate in safety programs. By training and experience, the physician is best equipped to judge the importance of physical and emotional factors which may contribute to accidents. Because the physician has the responsibility for treating the accident, closer cooperation between safety authorities and the medical profession in the investigation of how and why it occurred is necessary. Physicians can also contribute by community leadership and instruction of patients concerning common accident hazards.

The two age groups with the highest accident fatality rates are the very young and the very old. Most accidents in both these age groups take place in or around the home. Both are outside the influence of the organized safety work carried on by schools, industry and highway safety groups. The physician, as family health counselor, is well qualified to take the leadership in studying and working to prevent accidents to those under 5 and over 65 years of age.

To illustrate the extent to which physicians are already actively contributing to the prophylaxis of accidental trauma, let me describe the present organized effort which involves important segments of the medical profession.

National Safety Council

One of the chief divisions of the National Safety Council is the Home Safety Conference which has a section on Medicine and Public Health. Through this organization the Council cooperates with the American Medical Association, the American Public Health Association, the American Academy of Pediatrics and many other medical and public health groups. Examples of cooperation are the joint meetings between the National Safety Council and the American Academy of Pediatrics in 1950 and 1952 when outstanding programs on accident prevention in children were presented in the Grand Ballroom of the Palmer House to an audience of pediatricians and safety workers attending the annual conventions of the two organizations. The National Safety Council works through community chapters. Many of these have physicians on their boards.

American Public Health Association

Many public health officers are giving attention to the growing importance of accidents in the health picture. The U. S. Public Health Service has established a home accident prevention unit. Several years ago the American Public Health Association created a Committee on Home Accident Prevention. This committee has been active in stimulating studies by local health departments, especially to secure more accurate data on the cause of home accidents. The technique of epidemiology, under the leadership of Gordon and Roberts at Harvard, has been applied to accidents. Recently the School of Public Health at the University of Michigan sponsored a three-day Conference on Home Accidents which was attended by more than 90 public health, safety and medical authorities from all over the country.

American Medical Association

The American Medical Association, through studies by its Councils and Committees and its publications, has for some years been concerned with accidental trauma. Only last week an editorial in the JOURNAL discussed home accidents and urged physicians to give active support to educational efforts to reduce them. The Board of Trustees of the A.M.A. at the Clinical Session in Los Angeles in December, 1951 put the Association on record to investigate the serious problem of childhood poisoning and to conduct a campaign of prevention. The Association's Committee on Pesticides of the Council on Pharmacy and Chemistry has been studying this phase of the accident problem as a part of its program of investigating the hazard to health of pesticides.

A Medical Society Program

What can individual physicians do about the prevention of accidental trauma? Some might say that practically there is little the physician can do to protect his patients from accidents. Many think otherwise. Perhaps a good way to indicate the possibilities is to describe the *child* accident prevention movement launched in 1950 under the leadership of physicians.

Education

In that year, the American Academy of Pediatrics established its national Committee on Accident Prevention. This Committee by means of personal correspondence, circular letters, round-table discussions, papers at regional and state medical meetings, exhibits at the A.M.A. and Academy of General Practice and state meetings, and medical journal articles is informing physicians about the child accident problem and suggesting methods of local solution.

The heart of accident prevention is education. The Committee believes the physician as family counselor in child rearing has the opportunity and the responsibility to include accident prevention advice in the health supervision program for the child. This advice has been likened to a new vaccine to be offered. But it is an immunization to be given to the parents rather than the children.

This safety immunization must fit the needs of the individual child and his environment. The needs can be seen most clearly by the physician who understands the home situation and is familiar with the child's growth and development. The vaccine is intended to increase parents' knowledge, understanding, and confidence in child management and care. Its administration should be timed to help parents anticipate risks for which reasonable precautions can be taken at various stages of development. Accident prevention education handled in this way becomes a natural part of the child-rearing program and is not likely to produce attitudes of anxiety, fear, and over-protection. The "dose" and the "technique" of safety education is a matter of professional judgment. The child's personality, his muscular coordination, his physical environment, and the parents' emotional attitude toward the child and the doctor, are factors which determine *what, when* and *how much* should be given. This new approach, based on an understanding of child behavior and growth, is the Committee's unique contribution to child accident prevention. It has been described for physicians in a brochure "Are You Using the New Safety Vaccine?"

Forty-two thousand copies of "Safety Vaccine" have been distributed in 27 states to physicians who have a substantial proportion of small children as patients. This was decidedly a cooperative project.

The Metropolitan Life Insurance Company produced the booklet. The Mead Johnson Company addressed 50,000 envelopes. State medical societies distributed it with a covering letter. In some states, the health department participated by covering the cost of postage.

This resulted in widespread interest among practicing physicians for a similar publication for parents. The Metropolitan has printed "A Formula for Child Safety." It contains the illustrations and text of the brochure sent to physicians. More than 483,000 copies of this publication have been distributed in eight months.

To help the physician in determining the "dose" and the "technique" there are many suggestions by authorities in this field. For example, Press has proposed that physicians give parents a home safety check list about the time the child is 8 months old. At this age, the accident hazard begins to increase. A check list on home and child safety may be obtained from the local health department or safety council and from the Metropolitan Life Insurance Company. Such a list, presented to the mother, taken home, filled out carefully and at a subsequent visit discussed with her, will do much to impress the whole family with the importance of the subject. The Children's Hospital of Boston has published a useful booklet on the prevention and first aid handling of pediatric emergencies which every home with children should have. The Cincinnati Children's Hospital also recently published an excellent pamphlet on this subject.

When the physician makes a home visit, there is opportunity for education too. Finding and advising corrective measures for such accident breeders as a carelessly placed roller skate, a medicine cabinet easily accessible to little hands or an unguarded

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Providence Journal Photo

Dr. George M. Wheatley, (center) Third Vice President of the Metropolitan Life Insurance Company, receives the Dr. Charles V. Chapin Award of the City of Providence from Mayor Walter H. Reynolds at the 142nd annual meeting of the Rhode Island Medical Society, as Dr. Albert H. Jackvony, president of the Society observes the presentation.

stair or window may be as significant a contribution to preventive medicine as recommending the removal of a pair of diseased tonsils. Such "environmental inspection" is an effective way to educate. Most people must have their attention directed to hazards before they recognize them.

One of the physician's most valuable allies in such educational efforts in many communities is the public health nurse. She is often able in repeated visits to give parents guidance for which the physician has neither time nor opportunity. In her own care and instruction, when bathing the new baby, demonstrating the preparation of the formula, etc., she can impress upon the family proper techniques which may avoid accidents. She is also in a position to know individual home conditions and to point out constructive action in regard to hazardous situations.

We have no accurate information on the number of physicians who give child safety instruction to their patients, but from the interest in these publications just described we believe it is increasing. Eighty-five percent of the membership of the Academy reported to our Committee that they now give such guidance as a part of health supervision. We find that some physicians have their own child safety check lists; some use a bulletin board where they post news clippings of accidents or pin up the pages from our "Safety Vaccine" brochure.

To sum up the use of the "safety vaccine" in everyday practice, there are five factors which must be considered if we are to develop a satisfactory "titre" of accident "antibodies."

1. We have to know the common or likely hazards at certain months or years of age. We have some data on this but more needs to be accumulated through research. We must develop effective means of discussing these hazards with parents in a manner which will encourage constructive action without creating unnecessary fear or alarm, or equally important, avoid feelings of guilt when a serious accident does occur.
2. We must be familiar with the characteristic behavior and drives at certain ages.
3. We must understand the emotional attitude and behavior of the parents toward the child and toward each other. The effect of a disregard of safety practices on the part of the parents should be pointed out. The value of a good example cannot be overestimated.
4. We must know the physical, emotional and intellectual capacities of the individual child.
5. We must know the environment, not only the physical setting, but the emotional climate in which the child is living.

Community Service

Another important aspect of the child accident prevention program is community service. An in-

creasing number of physicians are active in their local safety councils and are also cooperating with other community groups. At our Committee headquarters in New York not a day goes by that we do not get a request in our office from a practicing physician for speech outlines and slides we have prepared for use with professional or lay audiences. These talks to lay groups are impressive examples of public service by the medical profession. Accident prevention is an ideal subject for the public education or public relations program of a medical society.

Investigation and Study

In order for safety education to have significance, considerable knowledge must be accumulated about accidents in the community. A study of the frequency and types of accidents in one's practice or of those admitted to the emergency room of the hospital may be the starting point. How these contribute to the development of a program is illustrated by the experience of our Committee.

A survey to secure more information on certain types of accidents in pediatric practice was made among the 3,000 members of the American Academy of Pediatrics. Half of the case reports received were due to poisoning. Thirty percent were cases of burns.

It should be noted that this is not a complete report on accidents in pediatric practice. The Committee limited its inquiry to burns, strangulation and suffocation and poisoning due to toxic paint. But analysis of the returns brought the Committee face to face with two of the most serious accident problems in pediatric practice.

Childhood Poisoning

More than 600 deaths due to accidental poisoning in children are recorded annually in this country and the mortality reveals only a fraction of the problem. For every child death from poisoning, there are probably more than 100 cases serious enough to be brought to a hospital. More than 80 percent of these poisoning deaths are in children under 5 years of age. The great bulk are concentrated between the ages of 1 and 3.

The difficulty of diagnosing some poisoning and the possibility that other causes of poisoning are being overlooked have led our Committee to the conclusion that in large population centers satisfactory facilities for toxicological examinations should be available to all physicians. The increasing use of new chemicals for insecticides and other purposes in our daily living increases the need for this special laboratory facility. Equally important is the need for a poison-information center where the doctor in an emergency can get advice on the possible toxic agent in a proprietary product and advice on

therapy. With the aid of these facilities, practicing physicians as well as hospitals would be able to practice more scientific medicine not only in children but also in adults, especially those who may be exposed to toxic chemicals in their occupation.

Another aspect of the poisoning problem which calls for organized action is more informative labeling. In an emergency, the family as well as the physician may be working in the dark or even lulled into a false sense of security if the product swallowed by the child gives no hint of potential danger by misuse.

One tragic illustration of this need for more informative labeling came to the Committee's attention recently. A pediatrician reported that a little child of four died as the result of ingesting camphorated oil. The mother had used it as a home remedy for a respiratory infection. The child got hold of the bottle and drank some. The mother realized what had happened. She read the label. There was nothing on the label to indicate that it was a dangerous drug. She was an intelligent individual and reasoned that if it were poisonous, surely there would be a law requiring a poison label, or an antidote or a warning as to the maximum safe dosage. So she did nothing. About three hours later symptoms developed. The child was brought to the hospital where in spite of heroic measures, she died. She was the only child. The mother kept repeating "If I had only known."

Following a somewhat similar tragedy in one California community, pharmacists at the suggestion of local physicians now put warning labels on sleeping pills, heart medicines, aspirin, sulfa tablets, etc., reading "Keep out of the reach of children."

In adults, too, drugs are probably underestimated as a factor in accidents. This might well be the subject of study by an accident prevention committee of a medical society. Sometimes an uninformed individual undertakes self-medication with an unfamiliar potent drug. He may think if one dose is good, two doses are twice as good. Or he may take a drug under the wrong circumstances and end up not only accidentally intoxicated but also involved in more disastrous situations. Bromides, alone, or in combination with barbiturates, or with alcohol or with chloral hydrate, seem to be the most common type of dangerous self-medication.

The relationship of alcohol to accidents is so obvious and well-known that it requires no discussion. The Westchester County, N. Y., Medical Society led the way in getting legislation in New York State making an alcohol test compulsory for drivers involved in accidents. The leader is a police surgeon who witnessed too many highway tragedies involving drunken drivers.

There are three Federal laws designed to protect the public from accidental chemical poisoning. They are: The Caustic Poisons Act; the Food, Drug and Cosmetic Act; and the Insecticide and Fungus Act. These statutes are fine and useful as far as they go. But they are not adequate.

For example, with the introduction of new floor waxes which are complex plastics dissolved in volatile organic solvents, the toxicity of these ingredients and safe limits of inhalation exposure become a matter of great concern. The type of container in which highly toxic substances are dispensed is also a matter for study and action. For example, a group of four-year-olds were playing with a glass container of one of the organic phosphorus insecticides. It is estimated that 0.5 cc cutaneously absorbed is a lethal dose for man. Because the chemical produces no local inflammatory changes in the skin, absorption can take place by this route undetected until other symptoms begin. As could be anticipated, the glass container broke. One of the children was splattered with the chemical and died before reaching the hospital.

Mechanical dispensers of insecticide vapors can also be a source of poisoning. The A.M.A. has called attention to this hazard to health in the report of its Committee on Pesticides.

Our discussion of poisoning points up the need for the physician to consider today more than ever in differential diagnosis the possibility of chemical poisoning. We have already emphasized the desirability of toxicological laboratory facilities as an aid in diagnosis and treatment. As a further contribution to the study of the problem, death certificates should, in cases of poisoning, give the name of the active ingredient and the proprietary or trade name of the product suspected of having caused the death. The listing of both the active ingredient and trade name is necessary since so-called inert ingredients in many preparations may be responsible for death. Common offenders in this category are the solvents frequently used to carry the pesticide agent. The preparation of more factual death certificates will facilitate accurate tabulations on the causes of accidental deaths due to poisoning and will ultimately help reduce the loss of lives resulting from the careless use of highly toxic products.

Burns

We have mentioned burns as the other area of study and action which has grown out of our survey of certain accidents in pediatric practice. Our survey revealed 30 percent of all cases reported were burns; 60 percent of these were associated with flammable clothing. Burns are the second most frequent cause of fatal home accidents and account for about one-fourth of the total. Colebrook¹ found that 70 percent happened to children under 15 and

continued on next page

53 percent happened to children under 5 years of age. This study made in England on 2,000 consecutive burning and scalding accidents admitted to the Birmingham Accident Hospital found two factors were largely responsible for the seriousness of the burns: (1) contact with an unguarded fire, (2) the ignition of clothing.

Recently Moyer², a St. Louis surgeon, pointed out that 40 percent of his serious burn cases were in children under 11 years of age whose clothing had caught fire.

There has been insufficient study of the relationship of flammability of clothing to burns. Only when there are sensational episodes such as the cowboy suits a few years ago and the torch sweaters recently is the public made aware of the relationship of clothing to burning accidents. With the increasing use of synthetic fibres in clothing, it would appear more important than ever to prevent, by suitable pre-testing, the sale of dangerous fabrics especially for children who expose themselves to greater risks. In burning accidents, a sample of the clothing should be obtained if possible and subjected to a flammability test. A standard method for testing has been developed.

Under the aegis of the American Standards Association, two projects—one dealing with flammability of children's clothing and the other a labeling standard for paint products—have been started at the request of the American Academy of Pediatrics. The Canfield-Johnson Bill now being considered by Congress would prohibit trade in dangerously flammable apparel. It has received strong support from the National Retail Dry Goods Association.

These are the important developments and a summary of what our Committee has learned about two of the most important types of accidents in pediatric practice—burns and poisoning. The Committee's experience illustrates the value of beginning a program with a fact-finding approach.

Susceptibility to Accidents

Returning again to our theme of the physician's contribution to the prevention of accidents, let us consider the individual who has frequent accidents. The majority of accidents involve a relatively small proportion of the population. In adults, at least, there are many factors which account for this apparent susceptibility to trauma: defective coordination; inherent clumsiness; temporary impairment of motor skills brought on by fatigue, illness, medication or drunkenness; chronic impairment of motor skills as a result of faulty vision, deafness or neural lesions. Psychological factors may include tendency to absent-mindedness, emotional tension, accompanied by neuro-muscular tension and subconscious desire for involvement in accidents in order to express hostility or atone for guilt.

It is clear that the physician can make an important contribution to the prevention of accidents by recognizing these factors and doing everything possible to eliminate them or aid the individual to avoid injury-inviting situations.

Undoubtedly physical and emotional factors are important in childhood injuries too but they may not have the same significance. Because of inexperience and immaturity, all children—especially those under 2 or 3 years of age—can be considered to some degree accident-susceptible. Much of a child's learning is through experience. He falls frequently before he learns to walk. He experiences minor cuts and burns before he understands the meaning of "sharp" and "hot." Very little study of the older child who has frequent accidents has been done. Recently Langford³ reported observations on a small group of youngsters between 6 and 11 who had had a large number of accidents and another group with no accident history. Both groups came from the same neighborhood and attended the same schools. Income levels and other factors were also similar.

Each child was given a complete physical, neurological, and ophthalmological examination and a battery of psychological tests. Personal data were gathered for each child. Factors in the family, neighborhood, and school environment also were investigated. The groups are too small to furnish data of statistical significance and only the most tentative conclusions can be drawn from a preliminary analysis of the data obtained. However, Langford reports that certain characteristics seem to stand out in the general behavior and reaction patterns of both groups. The accident-repeater child seems to be overactive, restless, and impulsive. He tends to want to be older than his age and does not seem to get a feeling of security at home. He tends not to retreat from dangerous situations and becomes more impulsive under stress. Children in the non-accident group appear to be more timid and submissive and to come from more closely united family groups. The investigators have evolved methods and techniques which show promise of giving excellent results not only in the study of child accidents but also in the study of other child health problems. These are promising studies. More research in this area is needed because it has great significance for prevention of all ages.

Traffic Safety

It is beyond the scope of this paper to discuss adequately the important area of traffic safety. It is largely a function of the police, and of state highway departments and traffic engineers. But we should not pass it by without referring to one aspect of the problem to which the medical profession can contribute.

It is shocking to discover how little evidence we have on the relationship of physical or emotional impairments to traffic accidents. The medical profession, through appropriate authorities and committees, might give more study to physical and emotional health of the 64,400,000 licensed drivers in the United States. Again we need to pay special attention to the young and the old. We cannot ignore the fact that the highest traffic accident rates are in youthful drivers. Since 1933, while the death rate from motor vehicle accidents in boys 10 to 14 declined 24 percent, in boys 15 to 19, it has increased 40 percent. Young drivers are a danger not only to themselves but to others. Chronological age is not a criterion of maturity, either in judgment or skill. Studies should be made to determine the value of certain types of physical and psychological examinations to this problem. At the other end of the spectrum is the aging driver. The press not infrequently reports auto accidents in which the elderly driver suddenly loses control of the wheel and is reported to have died of a heart attack. A recent editorial in the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION⁴ urged, as one important approach to the control of traffic accidents, the careful examination of patients known to drive cars. The editorial concluded by saying: "If the patient's life or the lives of others can be saved by a warning from his physician of the hazards of driving because of certain physical or mental findings, he will be experiencing an extension of medical care that is in keeping with the demands of modern life."

At a recent medical meeting one physician emphasized the importance of this by stating he had three epileptics who were permitted to drive and all three had been involved in accidents. He believed that legislation was needed to keep these individuals off the road. But we lack well-documented studies of handicapped individuals and car operation.

Industry

The reduction of occupational hazards, though a prime aim of industrial medicine, is largely the responsibility of industrial accident commissions and of safety engineers. So successful have they been that as was stated earlier the worker is safer on the job than on the highway or at home. But the alert physician should judge with great care the influence of physical or emotional disorders on the ability of the worker to perform his job safely.

Home Accidents

In conclusion, it is in the study and prevention of home accidents that the physician can make the most important contribution, one which is in fact unique. As previously stressed, home accidents are second only to motor vehicle accidents as a cause

of accidental death and serious disability. Earlier we said that the age groups chiefly affected were those under 5 and over 65 and that the physician had special access to these age groups. To illustrate the opportunities and potentialities for medical participation in accident prevention, the program for accident prevention in children of the American Academy of Pediatrics was described.

We believe the time has come for the medical profession to assume a role of leadership in the prevention of accidental trauma. We suggest that the component units of organized medicine form committees to develop and carry out accident prevention programs in cooperation with other appropriate and interested agencies. The program ought to embrace all age groups but be focused where the results may be most fruitful. This appears to be at the beginning period of life, not at its terminal stages—though these should not be ignored. Such a program might embrace the following ten points:

1. Determine the magnitude of the problem in the community.
2. Learn what is being done about it.
3. Decide the special contribution of organized medicine in solving some of the problems. In this connection, the role of the Women's Auxiliary should not be overlooked.
4. Give particular attention to safety in hospitals and office practice.
5. Cooperate with those who are trying to enforce safety laws and to develop such laws.
6. Plan medical society meetings, e.g., using accident cases to emphasize causes and means of prevention.
7. Encourage more accurate and complete accident records and death certificates. Histories should include *how* and *why* the accident occurred.
8. Develop centralized information service for poisoning emergencies and toxicological examination.
9. Teach patients safety, urging special caution in presence of physical or mental impairments.
10. Urge physicians to practice safe habits themselves.

Medicine and public health have played major roles in the battle which man has been waging with his environment in the past fifty years. This struggle resulting in a remarkable degree of control has been directed against the communicable diseases. The means of control have been sanitation, immunization and the newer antibiotics. Today, machines and toxic chemicals—thanks to our technological progress—loom as greater threats to life than germs. The protection of the individual from

concluded on page 441

WHY MEDICAL EXPERTS DISAGREE*

JOHN E. DONLEY, M.D.

The Author, John E. Donley, M.D., of Providence, R. I., Past President, R. I. Medical Society; Medical Director, R. I. State Curative Centre.

How may a man know whether he be so earnest is worth enquiry; and I think there is this one unerring mark of it, viz, the not entertaining any proposition with greater assurance than the proofs will warrant.

JOHN LOCKE—*Human Understanding*

A FEW DAYS AGO, I met a friend of mine, one of the younger lawyers, who said to me, "I understand that when the doctors and lawyers meet next Monday night you are going to criticize the lawyers." Sensing, as I thought, some slight tremor of trepidation in his voice, I hastened to assure him that I am not going to criticize the lawyers whom I both admire and esteem. Nor do I intend to criticize the doctors. As I understand the purpose of this unique occasion, we are gathered to engage in friendly and, I am sure, rewarding discussion of some of the problems which frequently arise to perplex and perhaps even divide our respective professions. And so it is good for us to be here to exchange opinions and to become better acquainted with one another, not personally only but professionally as well.

In the brief time at my disposal, I purpose to say nothing about the numerous questions which will, no doubt, be asked and answered during our later panel discussion. I shall, therefore, confine my remarks to a subject which I have long had in mind, namely, the criticisms which for many years have been leveled at doctors when they appear as witnesses in courts of law. We have been told by judges, by attorneys, and by laymen, not without occasional acerbity, that medical expert testimony is frequently discredited and disbelieved because the experts are practically certain to disagree. We doctors are naturally disturbed by such criticisms; and if I can place before you, in summary fashion a few of the basic reasons for our differences of opinion, I shall be pleased because, like other doc-

tors, I have been accused of this misdemeanor and indeed on several occasions in court was gently reproved for disagreeing with myself. May I ask you then to accept my remarks as a modest apologia for the doctors.

With that intellectual innocence so characteristic of my profession, I used to believe that in their opinions only doctors disagree, while lawyers, with respect of their cases, enjoy, for the most part, unity, peace and concord. This belief of mine was quickly dispelled when I came to read some of the writings of Mr. Justice Cardozo. Lecturing to the law students of Yale University on the *Nature of the Judicial Process*¹ and describing the difficulties which confront judges and attorneys when they endeavor to extract from the precedents before them the underlying principle, the *ratio decidendi*, this is what he said, "Cases do not unfold their principles for the asking. They yield their kernel slowly and painfully. The instance cannot lead to a generalization till we know it as it is. That in itself is no easy task. For a thing adjudged comes to us oftentimes swathed in obscuring *dicta* which must be stripped off and cast aside. Judges differ greatly in their reverence for the illustrations and comments and side-remarks of their predecessors, to make no mention of their own. All agree that there may be dissent when the opinion is filed. Some would seem to hold that there must be none a moment thereafter. Plenary inspiration has then descended upon the work of the majority. No one, of course, avows such a belief, and yet sometimes there is an approach to it in conduct. I own that it is a good deal of a mystery to me how judges, of all persons in this world, should put their faith in *dicta*. A brief experience on the bench was enough to reveal to me all sorts of cracks and crevices and loopholes in my own opinions when picked up a few months after delivery and re-read with due contrition. The persuasion that one's own infallibility is a myth, leads by easy stages and with somewhat greater satisfaction to a refusal to ascribe infallibility to others." These words of Mr. Justice Cardozo are no doubt well known to the lawyers here present. I quote them so that my medical colleagues may take heart when apprised on such eminent

*Introductory remarks delivered at a joint meeting of the Rhode Island Bar Association and the Rhode Island Medical Society, at Providence, R. I., April 27, 1953.

¹*The Nature of the Judicial Process*. Yale University Press. New Haven, Connecticut. 1921.

authority, that expert lawyers, as well as expert doctors, may disagree. And may I remind you, in passing, that Mr. Justice Holmes gained and merited international fame as the Great Dissenter, and that he was praised rather than criticized by his profession. It comes then, I suppose to this, that when we leave the realm of abstract thought and descend to individual concrete reality, we are, all of us, both doctors and lawyers, in the same unpleasant, but very human predicament.

If then we would apprehend the obstacles which doctors must surmount in arriving at their professional opinions, we shall bear clearly and constantly in mind, that medicine has always been, is now, and in the foreseeable future must continue to be a practical art which deals with that querulous, intractable, unreasonable creature, man. It is true enough to say that medicine, in a limited area of its domain, accepts gratefully the gifts and appropriates the methods of applied, and, on occasion, of experimental science, but in handling the majority of its concrete problems, it still remains a practical art. Unlike the arts and sciences which are concerned with inanimate nature, the doctor cannot control and specify the material with which he must work. He cannot with the mathematician ascend to the empyrean, there to indulge his taste for abstract deductive logic; nor can he always employ the quantitative methods of the physicist, the chemist or the engineer. He must take his material as he finds it, with all its multifarious complexity and work with it as best he can within the limits imposed upon him by his present knowledge, his experience and his techniques. He must deal, as do his brethren in the legal profession, with constantly variable and unpredictable objects, namely, living men and women. By the nature of his profession, the doctor is immersed in the concrete, bewildering manifold of the world and the people about him. In Bacon's words, his mind "works upon stuff" and upon this ever changing manifold, he must try to the best of his ability to impose some semblance of order; first, that he may arrive at a diagnosis of his patients' condition; secondly, that he may treat them intelligently; thirdly, that he may predict the future course of their maladies.

It is interesting to pause for a moment and to look at this Greek word diagnosis. To the Greek it meant to know through and through, that is, to know thoroughly. Thought, therefore, should correspond with thing. And how is this correspondence to be brought about? Obviously in two ways; first, by the careful selection and observation of the facts, not all facts, but significant facts; and secondly, by their truthful interpretation. Now a fact is something that has happened, is now happening or can be made to happen; and before this gathering, I need not insist on how difficult it is to get at the

facts. As Mr. Wilfred Trotter, the famous English surgeon was at great pains to impress constantly upon his medical students, "facts, unfortunately, are not the natural diet of the mind. They are laborious and often undignified to collect; they are apt to be formless, ugly and even nasty, they dirty the fingers, they smell and sometimes bite. How different from the noble, shapely and above all, well-behaved conceptions of the mind which are so manifestly of a higher order of realities. The fastidious Greeks were very sensitive to this difference and not a little apt to look down on the mere base collection of facts. Even the tremendous Aristotle was not quite untouched by this intellectual queasiness." Nor again do I need to insist that interpretations in medicine or in law, which are not based firmly on facts and enough of them, are no more substantial than gossamer, not even when they are adorned with all the finery of Mediterranean words. They are mere *flatus vocis* as the old medieval philosophers were wont to put it. To gather facts and to interpret them truthfully is no easy task; for it requires time, patience and persistence to read what Plato calls the "long and difficult language of facts."

But assuming that two equally competent men, doctors or lawyers, have got hold of the same set of facts, there is always the possibility of a difference in interpretation as to their meaning. Even the many splendid instruments of precision which now enhance the doctor's powers of observation and extend the field of his vision, do but multiply the occasions for differences of interpretation. Electrocardiograms do not interpret themselves, nor do x-ray films, nor do the changes of form and color seen with the ophthalmoscope in the back of the eye. All of these require accurate, precise interpretation; and this, in turn, will always be conditioned by the personal characteristics of the man who interprets. Whether he realizes it or not, the doctor or the lawyer cannot rid himself of his own mind and therefore his interpretations will be colored by his knowledge, his intuition, his experience, his aptitude for critical thought, his temperament even, and not seldom, his conscious and unconscious prepossessions. And when the doctor is on the witness stand, harassed by cross-examination, not always friendly, there are two potent emotional ingredients in the complex brew which produces the opinions he may entertain and express, that is to say fear, defect of self-reliance, and pride, excess of self-reliance; fear which often prevents him from defending what he does know and pride which tempts him to defend what he does not know. All of these components and others which I could mention, contribute their share to the forming of opinions which, in the nature of things, will and

continued on next page

must vary, and for which variability we doctors are blamed so frequently and often so unjustly.

And now lest I may seem to be occupying myself unduly with somewhat bloodless generalities, let me illustrate what I am attempting to say by a concrete example. My thesis is that in a given instance it is often difficult and sometimes impossible to come by the facts because of the gaps in our knowledge and the limitations imposed upon us by our methods of examination. Thus the frame of reference for dependable opinions is lacking. There are many morbid states for which, thanks to available scientific techniques, diagnosis and treatment can be definite and precise. But on the other hand, there is a multitude of pathological conditions concerning which our best efforts supply us with no more than a sum of probabilities, and it is these cases which give rise to differences of opinion among equally sincere and skilled observers. Let us look for a moment at a common and homely example, one which occurs frequently in our industrial society; I mean an injury to the low back.

A middle-aged man, let us say, consults his doctor because of pain in his low back and down the posterior part of one leg. He informs his doctor that while attempting to lift a heavy object a few days ago, he felt "something snap" in his back, and since then he has been completely disabled. Naturally he wants to know what happened to his back, what he is to do about it and how long he will be kept away from his work. To him these seem to be simple questions which, as he thinks, his doctor should be able to answer immediately. But while the questions are simple enough, the answers to them may be difficult and even impossible. After a longer or shorter period of conservative treatment and much careful study, the patient is believed to harbor a herniated intervertebral disc for which an operation is advised and performed. But, unfortunately, unlike many other patients who recover completely, this man continues, after his operation, to complain of pain and disability in his back, together with a variety of aches and pains in one or both legs. Indeed, as time goes on he may even enlarge the catalog of his troubles. He is then examined by a number of competent doctors, each of whom arrives at a different opinion as to diagnosis, prognosis and treatment.

And why these different opinions? If you reflect a little you will perceive that there are no objectively demonstrable phenomena open to the common observation of the examiners. Each examiner, in turn, is confronted by the patient's subjective experience of pain, ache, disability and the other complaints which make up his story, a story difficult to elicit and varying from day to day. And this brings us, face to face, with the mystery of pain, perhaps the most enigmatic problem in medicine and certainly the bugbear of diagnosis and treatment. I say this

with full awareness of the many excellent books, monographs and articles on the subject of pain, its causes, diagnosis and treatment. To enter into another man's subjective experience is an undertaking wherein the doctor is at the mercy of the patient. Not long ago, a man, with whose condition I am acquainted, remarked to another patient that the "nice thing about an injured back is that no one but yourself knows whether you have pain or not." But, you may ask, do not your x-rays, lumbar punctures and myelograms enable you to discover definitely what is wrong with an injured back? The answer is that sometimes they do, but often, unfortunately, they do not. And here we should beware of accepting the uncriticized assumption that because our rather gross methods of examination fail to disclose what is wrong, there is, in reality, nothing amiss. Frequently, in a moment of exasperation, we may declare that such a patient only "imagines" he has something the matter with him. How do we know this? We do not know it, we merely assert it. And as a great physician once remarked, how true it is that the human skin is a most effective barrier to our search for what is beneath and behind it.

I have been using the common back injury merely to illustrate how hard it is at times for doctors to come by the facts they need to serve as the basis for interpretive opinions. The famous hypothetical question, that extraordinary product of the legal mind, would have served my purpose equally well, or the proceedings in a will contest or the obscurities in the evidence so often present when insanity is the plea in defense of crime. The upshot of it all, I suppose, is this, that since we doctors, and you, our good friends the lawyers, are endowed with finite minds, making no claim to infallibility or omniscience, I fear that, with charitable tolerance, we must suffer differences of opinion for some time to come. And shall we not, therefore, agree that our own experience confirms what Hippocrates said twenty-five centuries ago, "—Life is short, the Art long, the occasion fleeting, experience deceptive and judgment difficult."

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INTUSSUSCEPTION, RETROGRADE (ILEO-ILEAL) WITH ASEPTIC STRANGULATION NECROSIS*

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RETROGRADE INTUSSUSCEPTION occurs rarely, and very few instances are found described in the literature. The following case in an adult is therefore of interest for intussusception in any form occurs infrequently beyond the age of fourteen. Furthermore, the one herein reported was of the rare ileo-ileal type, so-called enteric. Also, the finding of a 24cm. length of strangulated, necrotic ileum without infection and without peritonitis is reported.

M. B. (Miriam Hospital #34,166) female, age 40, was admitted March 2, 1950, at 7:00 P.M., with a history of generalized abdominal pain and vomiting of four days' duration. At the onset the pain was severe and crampy. It subsided after 24 hours only to return again 24 hours before admission. She had not passed feces or flatus for 24 hours. There had been no evidence of blood in her stools. On two previous occasions, two years ago and nine months ago, she had experienced attacks of abdominal pain of several hours' duration, simulating gall-stone colic. X-ray examinations, however, made after the last attack in Troy, New York, "were negative." An appendectomy performed seven years ago was the only relevant episode. Two children, aged 18 and 14, have had no serious illnesses.

On admission Mrs. B was noted to have only slight abdominal pain. She was well hydrated; her tongue was moderately coated. She appeared cheerful, in no apparent distress, and was sitting up in bed regarding her own illness rather lightly. The abdomen was rotund as one would expect in a somewhat obese woman. Tenderness and slight muscle resistance were noted in the right subcostal and right upper quadrant areas. Rectal and vaginal examinations revealed no positive findings.

Laboratory data: R.B.C. 4,600,000, Hgb. 90%, W.B.C. 12,400—6% juv., 4% stab forms, 69% seg., 21% lymph. Urine amber, 1030, acid, 4 plus acetone. Sed. rate 40 mm in one hour. Blood type

*Presented before the Providence Surgical Society, November 13, 1952.

O Rh plus. Blood sugar 104 mg. %, urea N 17 mg. %. Admission T.P.R. were 98.6—80—24, and remained so until operation.

An enema returned minimal amounts of liquid feces and flatus. A Levin tube was passed and connected to suction, because of persistent nausea. Dark green and brownish fluid was noted coming from the stomach. Intravenous fluids were given. A diagnosis of acute cholecystitis, with question of intestinal obstruction, was made. Nausea and slight abdominal pain in the r.u.q. continued. She was taken to surgery on the second hospital day, at about 18 hours after admission.

Operation: March 3, 1950: The abdomen was opened thru a transverse r.u.q. incision. A great deal of clear serous fluid was encountered. The gall-bladder was somewhat distended, thin walled, free of inflammatory reaction, adhesions and stones. The exploring hand encountered a mass in the left lower quadrant. There was no fixation so that the mass was easily delivered thru the incision. It was found to be intussuscepted ileum of the ileo-ileal variety. (See specimen) However, this was not readily obvious. At first inspection there seemed to be an absence of continuity between the end of the mass and the healthy ileum distally. The intervening section, 3 inches long, presented a strand of stringy, flabby, gray, necrotic tissue which had lost all identity to any recognizable structure. A purulent reaction was not present. It was soon recognized that the intussusception was in reverse—that is, the distal ileum with its mesentery was contained in and strangulated by the proximal ileum. (See specimen) By picking up the necrotic ileum and following it distally, healthy collapsed ileum was brought out of the abdomen. The absence of peritonitis, beyond a serous reaction, was surprising in view of the presence of complete obstruction, strangulation and necrosis of three inches of small intestine.

The involved gut was excised between Kocher clamps. The ends were closed and a side-to-side anastomosis constructed. The ileum proximal to the obstruction was greatly distended. This distention was overcome, previous to the resection, by inserting a catheter thru a sealed off stab wound. Contained air and much dark fluid were removed by means of suction intermittently broken. The catheter was Witzelized, then led out of the ab-

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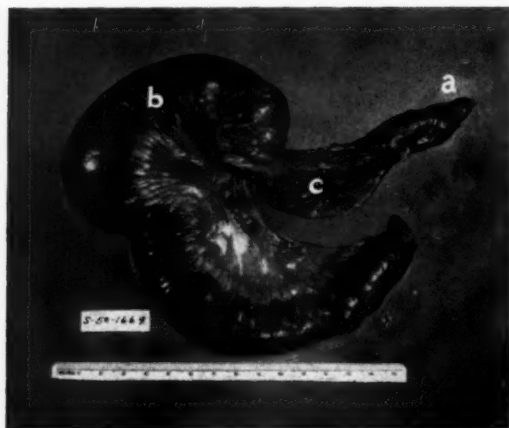
domen thru a stab wound for gravity drainage. Abdominal closure was with 00 chromic continuous for the peritoneum, interrupted #30 cotton for the aponeurotic, fascial and skin layers.

Pathologic Specimen: (Institute of Pathology, Rhode Island Hospital) "Specimen consists of a segment of small bowel, the proximal 30 cm. being distended and filled with a hemorrhagic material. At the distal end of this, there is an intussusception of the distal portion into the proximal portion. From this area of intussusception there protrudes 9 cm. of grayish-brown, gangrenous bowel, at the distal tip of which there are 2 cm. of apparently normal but collapsed bowel. No perforation is evident in the gangrenous portion. Upon opening this, the intussusception is found to extend proximally for a distance of 15 cm. No perforation of the intussuscepted portion is found. Within the lumen, at the base of the intussusception, just proximal to the area which is gangrenous, there is found a polyp on a pedicle. The polyp and pedicle together measure 3 cm. in length, the polyp measures 1 cm. in greatest diameter." Dr. Wesley Roberts.

Microscopic description: The histologic picture is one of gangrene of the intestine, apparently, on the basis of infarction of arterial obstructive type. This is consistent with the picture produced by intussusception.

Pathologic Diagnosis: "Mucosal polyp with intussusception, atypical, of small intestine." Dr. William M. Cannon.

Progress: The patient recovered rapidly following the intestinal resection and anastomosis. 500 cc of matched type O-Rh positive blood was given soon after she was returned to her bed. Penicillin SR 400,000 units was administered for five days.



SPECIMEN

- (a) Distal ileum, (b) Proximal ileum, intussuscepted,
(c) Strand of gray, necrotic tissue.

On the day following surgery she was passing some flatus by rectum. She left the hospital free of all symptoms on March 17, 1950, fourteen days after the operation. Because of the possible presence of other polypi, she will be advised to have x-ray studies of the alimentary tract.

Discussion

Laufman experimented with loops of intestine deprived of all direct or indirect blood supply and disconnected from the main stream of intestinal fluid content. These isolated segments of intestine were left open intraperitoneally after being made relatively free of pathogenic bacteria. Intraperitoneal autolysis of the host's own intestine took place without producing any apparent harm. The shock-like state or death of the animal, which occurs in the classical instances of untreated strangulating obstruction or in the presence of constant spillage of intestinal fluid laden with pathogens, was not seen under the controlled conditions of these operations.

The sequence of events in the patient presented appears to approach those observed in Laufman's controlled experiments. The bowel distal to the obstruction in all probability early evacuated itself. It became completely collapsed and empty before the gangrenous process began. It therefore became relatively free of pathogenic bacteria. At least, this is a fair assumption. Perforation did not occur in the area of gangrene since distention was not present. The reverse may be true in the common forms of intussusception in which the strangulated mesentery and bowel are in the cephalad position and in the zone of distention. Here perforation may take place in the attenuated bowel in the area of necrotic tissue. Constant spillage of toxic, bacteria-rich, intestinal fluid would then lead to purulent peritonitis, and an extremely ill patient.

Groper's review of retrograde intussusception indicates that any portion of the gastro-intestinal tract may be involved. His classification cites the varieties that have been encountered. There are many reports of a loop of jejunum finding its way into the stomach thru a previously constructed stoma of a gastroenterostomy. (Herbert). A rare variation was mentioned by Watson and Crandall: retrograde intussusception thru an enteroenterostomy into the stomach. The purely enteric variety is exemplified by the present case report. For the cecum to enter the terminal ileum would seem impossible, but this occurrence has been reported by Goodyear. The compound types refer to instances in which a retrograde invagination is superimposed on a direct one, or vice-versa.

According to Groper, Todyo found three instances of retrograde intussusception in a review

of 150 cases, while Fitzwilliams found six retrograde in 1000 cases. Perrin and Lindsey noted an incidence of three in 400 cases: two were enteric, and one was jejunogastric. Groper concludes that retrograde intussusception may occur whenever the neuromuscular mechanism of the intestine is thrown into reverse. The fecal vomiting of ileus is cited as a classic example of the reversal or perversion of normal peristalsis. At autopsy instances of retrograde intussusception as a result of agonal vomiting have been reported. Perrin and Lindsey mention perverted peristalsis, paralytic conditions of the intestine, congenital abnormalities, new growths, and swelling of preexisting lymphoid tissue as inciting factors that may cause reversed peristalsis. Groper adds the use of strong cathartics as a cause. He warns that the use of enemas for diagnosis or for reduction may not be without danger. Especially in retrograde invagination of the large bowel the defect could be aggravated.

Elliot-Smith states that intussusceptions confined to the small intestine present less severe symptoms rendering diagnosis more difficult, operation late, and gangrene more frequent than in the ileocolic variety. Diagnosis before operation is difficult in the enteric invaginations since a palpable tumor is apparently not as common as in the ileo-colic cases. Of the 400 instances studied by Perrin and Lindsey, only 27 were purely enteric, and only eight of these presented a palpable tumor.

Cioffi, Ryan and Groper each present single case reports of retrograde intussusception. Some of the facts presented relating to their patients are quite similar to those found in my case report.

Summary

Retrograde intussusception of the ileo-ileal type is described. This is of extremely rare occurrence. Strangulating obstruction with ensuing gangrene of the bowel over a length of 9 cm. distal to the intussusception occurred. Perforation and spillage, however, did not follow, and peritonitis did not occur. The patient presented none of the ill effects usually expected in such a serious lesion. The similarity of the clinical picture and pathological findings to those portrayed in certain experiments in dogs performed by Laufman are stated. It would appear that in the human, under certain favorable circumstances, the peritoneal cavity can tolerate gangrenous bowel devoid of all blood supply and relatively free of pathogenic bacteria without developing peritonitis and all of the other lethal features usually accompanying gangrene of the bowel due to strangulating obstruction.

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THE PRACTICING PHYSICIAN AND ACCIDENT PREVENTION

concluded from page 435

these and other causes of injury is a challenge worthy of the skills of modern medicine and public health. Accident prevention has the added value of being an ideal subject for the public relations program of the medical profession.

Accidental trauma, of all the leading causes of death, offers the most promise at the present time for further substantial improvement in life expectancy.

"Deaths by accident are just as truly preventable as are deaths from diphtheria and typhoid fever, and it is high time that we did something energetic to prevent them." The man we honor tonight said this one day in May almost thirty years ago.

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DOCTORS AND HOSPITALS*

PHILIP D. BONNET, M.D.

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DOCTORS AND HOSPITALS are at present being tested by the fire of public opinion. In specific situations, there is abundant evidence of great confidence in individual physicians and individual hospitals but, in the aggregate, there is abundant evidence of a lack of confidence in physicians and hospitals as a whole. Some of this lack of confidence can be dismissed as unreasonable expectations. There is nothing new about that. Throughout recorded history, the doctor has been concurrently praised and blamed—and probably he has been often unjustly praised as well as unjustly blamed. Because, however, of the new tools of communications which we have today, more is heard of our failure to meet needs and demands, and it is forgotten how easy it is to have ideas about what someone else should do—like the rocking chair tennis player—and difficult, as always, to translate ideas into effective usefulness.

If the truth were known, doctors and hospitals—that is medical care and health services in the broad sense—have never been more efficient—have never been more effective. And this is true not only in terms of lower death rates, increasing life span, and declining incidence of infectious disease, but also in the quantity and quality of services rendered without any increase in the relative cost. To my knowledge, the only attempt to document this efficiency and effectiveness has been made by Dr. Frank Dickinson, the able Economist of the American Medical Association. Today a week's wages will purchase twice as much physician's services as in the period 1935-39 and the same week's wages will purchase 10% more hospital services than in 1935-39. At the same time the services rendered by each individual doctor on the average have increased almost in the same proportion. (Frank Dickinson: *What We Get for What We Spend for Medical Care*—1952 Panel on Financing a Health Program, the President's Commission on the Health Needs

of the Nation). According to Dr. Dickinson—no other "industry" can match the increase in "productivity" which has occurred in medical care service and the quantity statistics used in measuring this increase in productivity cannot of course reflect the quality of each service which as we all know has advanced with startling rapidity. As one indirect measure of the improvement in quality, the declining mortality from ever more terrible wars can be cited, while at the same time the ratio of doctors to troops has also declined. An uncharitable statistician of course might draw from these military figures, the completely erroneous conclusion that the doctors were the cause of the higher mortality.

Most of our current problems stem from this startling success and increasing effectiveness. The availability of effective methods and skills almost always leads to a recognition of needs to use them and recognized needs—particularly in the field of health—quickly become translated into demands. We are now faced with demands which exceed the possibilities of the supply of service—and the demands are a recognition of our degree of success. As Dr. Luccock of Yale, a theologian, has put it—"Like Alexander the Great, we have marched off all of the existing maps." Therefore we must pause a moment and try to take some bearings.

Let us first take a look at hospitals for they have not always been what they are today. In the beginning, hospitals were instruments of society for purposes other than medical care. They were *shelters* for all kinds of unfortunate people but primarily for purposes of segregation—the leper, the insane, the person with infectious disease, the handicapped,—all were, in effect, cast out of society permanently or temporarily. Some medical care—such as it was—was given to these poor people confined (note the word confined) in hospitals by dedicated individual doctors and attendants. But the purpose of the hospital was not originally to make medical care possible. It was to allay the fears of society by segregating the sick who were thought to endanger society. Beginning one hundred years or so ago—all of this began to change—medical science advanced steadily and rapidly and part of the advances were made by intensive study of the sick people in hospitals. The place to learn about sickness and sick people came to be the hospital where the sick people

*Presented at the 142nd Annual Meeting of the Rhode Island Medical Society, at Providence, R. I., May 6, 1953.

were and so hospitals became an essential resource in medical education. The first step in the change in hospitals was anesthesia—which made elective surgery possible. The half century ending in 1890 can be called the period of the “conquest of pain.” The second step was the antiseptic and aseptic method—which made surgery safe. The half-century ending in 1940 culminating in the development of antibiotics can be called the period of “conquest of fever” or infection. We are now in a new period—and I suggest that we are in the opening phases of the period of the “conquest of disability.” Of this period the new emphasis on rehabilitation is a sign.

Each step of the way of this advance doctors and hospitals have worked together but both have been oblivious of the change in the fundamental character of a hospital. No longer is it an instrument of society as a whole—no longer is it a place of segregation and “confinement.” It is a place of active medical treatment, a reservoir of special skills and an aggregate of technical equipment. It is a team of many people. Nevertheless, the idea persists that doctors and hospitals are two separate and distinct things which must be forever kept sharply divided.

We must face the fact that this cannot be so. Doctors and hospitals are not two separate things nowadays. They are two aspects of the same thing—namely, health services. The hospital has now become an indispensable instrument of doctors. Sixty years ago, all the tools which any doctor anywhere might have or use could be packed in the famous black bag and carried around by the doctor. That famous black bag has grown and grown until now the tools available to a doctor—operating room, laboratories, x-ray departments—are so huge that no one can lug them around. The gravitational attraction of this mass of essential tools cannot be escaped. Special notice should be taken of the fact that this attraction does not come any longer from the existence of beds in a hospital—though they help—but because hospitals have the capital investment in essential tools and the technicians necessary to put many of the tools to effective use. Doctors and hospitals are now more interdependent than ever before and must find new ways of working together. Even though the organizational form and structure of hospitals have not changed significantly, the fact is that the doctors have “taken over” the hospitals—This was proper, necessary and accomplished with the consent and assistance of trustees and society. But it occurred without any clear understanding that it was happening.

Now let us look briefly at the doctor. A century ago it was the “horse and buggy” doctor—doing the best he could to be all things to all sick people—a pillar of strength in time of trouble but able usually to comfort rather than heal. Just as the horse and buggy has become a 100 h.p. car and the

black bag has become a hospital or a medical center, the doctor, too, has grown and expanded beyond the compass of an individual into a roster of thirty or so “specialists” each with his own range of knowledge and technical skills. But we must not forget that the technical skills themselves do not make a doctor, however important they are. It is the character, courage, the judgment, the self-discipline, the kindness and the wisdom that are important—for they determine the confidence of the patient.

What is the common denominator among these evolutionary changes in doctors and hospitals? It is *growth* in all of its forms—mostly growth in specialization or, in biological terms, differentiation and growth in that essential concomitant of differentiation, organization. This is the secret of the increase in productivity, in efficiency and in effectiveness just as it is in every aspect of civilized society. Without specialization and without organization, civilization can never exist. Our civilization has carried the development of these principles far beyond any other civilization of which we have any knowledge.

But—no progress is made without creating new problems and finding solutions to them.

There is no gainsaying the existence of many problems, confusions, and misunderstandings among doctors, hospitals and patients—actual and potential. The criticisms are many and they have seemed until quite recently to have been increasing in frequency and severity. Some familiar allegations are: there are too few doctors, they are in the wrong places, hospitals are trying to practice medicine and “take over” the doctors, medical education is too long and too expensive, medical education is not as good as it should be, nurses are not nurses anymore, hospitals are too expensive and cold-blooded, the patients are not getting all the care they need and the care is not as good as they should have and so on around the circle again. It is possible, of course, to cite specific instances where each one of these things is or has been true and many more beside. But none of these—not one of them—is true as a generalization. But these problems are the price of our successes and a reflection of the lag in our abilities to keep up with the expectations of public opinion.

The specific problems which I wish to review briefly are: 1) the financing of health services and 2) the organization of health services—These are really opposite sides of the same coin but we must consider them one at a time.

The Financing of Health Services—It is an interesting statistical fact that in the aggregate the American people spend only 4% of their aggregate disposable personal income for all medical care services—which includes doctors, hospitals, over-

continued on next page

the-counter drugs and sundries, and dentists. This figure of 4% has been nearly constant for as long as the data have been recorded. It is well known also that the American people in the aggregate elect to spend substantially more than this for recreation, alcoholic beverages, tobacco, jewelry and cosmetics. The only point to be made is that the American people can afford to spend more than they are now spending for medical care services—if they can be persuaded to do so. There is much support for the belief that the American people should be persuaded to spend more than they now do—for health services are, in my opinion, seriously underfinanced. The places where underfinancing of medical care is at present most acutely felt are in the centers of medical education and in the hospitals. The most acute shortage is in capital funds for buildings and equipment but the shortage of operating funds to pay adequate salaries to an adequate number of people, many of whom must be trained on the job, is hardly less acute.

The problem is to devise stronger methods of financing. The doctor has an important part to play in making this possible because he must recognize the need before the public will be convinced of the necessity.

Let us look at some of the present economic physiology of medical care. It is often assumed that the burden of illness over a lifetime is borne almost equally by every individual. This is so obviously not so that it is often overlooked. The burdens of illness are unequal at different ages, the need for health services is different at different ages and even more important in different individuals at the same age. In short, the burden of illness is very unequally distributed. If this be so, can we safely assume that it is possible for each individual in the long run to be medically self-supporting? Of course, we cannot assume this and any satisfactory plan for financing medical care services must take this problem into account. The traditional sliding scale fee in accordance with ability to pay did take this into account. With the greater complexity and unit expense of modern health services, however, it is no longer possible to spread this risk only over those who are sick. It must now be spread also over those who are not sick. This is, in effect, the principal accomplishments of Blue Cross and Blue Shield, and other prepayment plans using the insurance principle. There are however, as yet no provision for adequate sources of capitals. Payment of capital costs is at present excluded from these plans.

In the last analysis, there is only one source of all financing in our industrial economy—what is known as economic production or the gross national product. Our problem is to open sluiceways for this money to flow into all of the essential and construc-

tive efforts of our society. There are in fact only four possible methods for paying for medical care services—namely:

- 1) Direct charges paid from savings, current income or on credit from future income. Direct charges have never included capital costs and it is doubtful that they can do so.
- 2) Prepayment plans which are in effect a form of savings which if not required for the care of one individual are applied to the expenses of someone who does require care, in which instance it becomes a form of the third method:
- 3) Donations—these whether in money or in service are the lifeblood of our medical care services because they indicate the extent to which people care that the sick receive the needed services without economic burdens being superimposed on the burdens of illness.
- 4) Taxes or — paradoxically — involuntary donations. At the moment, taxes are the most frequently advocated source of capital funds. The problems and dangers are many and great. Taxes do not create money which does not exist.

All four of these methods have existed side by side for years in varying proportions and all four together have never provided a complete answer. How much less of a complete answer would any single one alone provide?

We must continue all four methods in active use and strengthen each and every one so that the total more nearly approaches enough. There is a place for each and every one. At the moment, prepayment plans are in the ascendant as they should continue to be. Taxes have a place but should be kept in their proper place. Donations must be increased. It is my considered belief that the aggregate amount paid by the American people for medical care services can and should be increased by 50% or from 4% to 6% of total disposable personal income. There is only one way, however, by which that can be done and that is by "salesmanship" including ethical advertising. Every good idea, product and service must be sold. People must be convinced of its value so that a need becomes a demand. Then when the demand exists, a method must be devised to enable people to pay for what they want.

One thing is obvious—and that is that the present financial structure of health services which was set up in the aristocratic tradition of largess from a few is becoming obsolescent and must be transformed to fit the new traditions of economic democracy.

Organization of Health Services—With a few notable exceptions, the organization of health services is fragmented and individualistic—a survival of the days of the true solo practitioner and the independent institution. As specialization of doctors

has steadily advanced, however, with the concomitant specialization of a large variety of technical assistants, the need for organization has steadily advanced also. Specialization and organization must go hand in hand or the specialist ceases to be as effective as he might be. Organization provides the intercellular cement, the interstitial fluid, the matrix in which the differentiated cell can function and without which it cannot function.

The places where the weakness of organization are most apparent are in the provisions for family health supervision and in the relations between doctors and hospitals—both the staff organization within a hospital and the relations between hospitals and doctors who are not on hospital staffs. How can the counterpart of the pediatrician who has done such a brilliant work supervising the health of children be made available to all age groups? Industry is trying to provide some of this kind of supervision for working people but what of the non-working people? The present shock troops in the front line—the “general practitioner”—are too often overburdened to do this job. The tools and the necessary technical assistance have not been as accessible to him as they should be. It is recognized now that every physician needs a hospital affiliation—but how to accomplish it?

Within the hospital, the doctors must somehow be brought into effective partnership with trustees and administration. Time must be found by busy practitioners to study and solve the problems of organization. The doctors do in fact have the authority for important aspects of hospital policy. The trustees, however, have much of the responsibility and are glad to relieve the doctors of as much of this as is practical. But somehow the authority and responsibility have become dislocated so that neither side quite understands the other. Organization is merely a means to an end—a tool—and must be fashioned and developed by those who use it.

Do we know how health services can best be organized? I submit that we do not. There are many exploratory attempts being made and many patterns being studied—there are group clinics, partnerships, labor union clinics, industrial programs, public health departments, hospital staff organizations, joint conference committees, doctors as hospital trustees, and so on. Each in its own way is struggling to find the answer to the organization of health services. Again it seems that each pattern has some shortcomings which makes it inapplicable generally and we come back to the need for a multiplicity of methods without however, unnecessary overlapping and duplication. There is no single formula or facile answer. In seeking answers, there are several important considerations that should be kept in mind—

1. Are the methods and techniques which grew up in the time when acute episodic sickness was the principal concern of doctors equally applicable and effective when conditions of chronic continuous disability are becoming the principal concern of doctors? There is some evidence that continuity of care and health supervision is more essential than ever before. Is this perhaps one of the main reasons we are looking at the general practitioner with renewed interest?
2. The capital investment required for the tools of practice including hospitals and medical schools, grows steadily larger. Adequate capital financing is a problem of organization. Can a non-profit system develop adequate capital? Up to now, it has done reasonably well but it is now not enough.
3. The confidence of the patient in the doctor must be safeguarded as far as possible, but in a fluid and mobile society such as ours in many cases there is frequently neither time nor occasion for this confidence to develop spontaneously. A way must be found to cultivate it. It cannot be all made to shift for itself. And it probably cannot be based as in the past solely on one individual doctor for each person.
4. The standards of care must be safeguarded. The modern voluntary hospital has in fact become in the public mind the symbolic guardian of standards. The hospital is where the unattached patient turns if he can in time of need. The educational medical center with its hospitals is a prime mover of progress.
5. The availability of medical care services must be measured in travel time rather than in linear distance.

These are only some of the considerations which must enter into an effective pattern of organization and each must be adapted to the local situation. Our real problems are entailed in distribution—just as they are in agriculture and industry. Industry is somewhat ahead of us but that is largely because of more effective financing. And yet in spite of all of the limitations, the efficiency of medical care services has not lagged behind. How much greater efficiency would be possible if we could be better financed and better organized? There are indications that better care might be possible with the same expenditure as at present with adjustments in organization. But it is doubtful that this would provide for capital requirements.

Doctors and hospitals are the inheritors of a great tradition. We are dependent on one another and should become true partners in carrying on the tradition of dedicated service. We are volunteers in the search for health—in the war against illness

concluded on page 465

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MALPRACTICE IS YOUR PROBLEM

WE HOPE that every member of the Society has taken time to read and digest the list of "Do's" and "Don'ts" on how to avoid a malpractice suit that the Committee on Medical Defense and Grievance prepared and distributed. The concise list certainly pin points the major issues that give impetus to suits for malpractice. And the list is one that should be retained by every member, and read once in awhile to remind himself of the dangers that are ever present.

By accepted definition the term "malpractice" means the treatment of a person by a physician in a manner contrary to accepted rules and with injurious results. If all problems were decided on the basis of this accepted definition the malpractice issue would be relatively simple. But legal interpretations have widened the definition and insurance carriers have been willing to settle cases out of court to reduce possible costs, and presumably to save the doctor embarrassment of a court appearance which might otherwise result in defeat of the threatened suit.

Unfortunately the problem is enhanced in recent months by the continuous bombardment of the public with articles in popular magazines under such subtle titles as "How Much Surgery Is Unnecessary?", "Are Your Doctor's Fees Fair," and

similar headings. All these pseudo-attacks add to the confusion of the general public, rather than its enlightenment, and the deeds of a minority of unscrupulous doctors become accepted as the pattern to be expected in general. Consequently it is little wonder that the vindictive patient becomes worse, the disgruntled patient vindictive, and the threatened malpractice suits more numerous.

Paid losses are not increasing, according to the best knowledge we have of insurance experience with malpractice coverage, but the incurred losses — the estimated sums set aside to provide for potential loss from threatened suits — has risen considerably. This has in part caused the premium rate increase, although leading insurance authorities are quick to point out that the liability insurance rates had not been raised in many years and were due to go up in line with the present economic inflationary pattern.

The fact remains that every physician must have liability insurance. The cost of that insurance will continue to be predicated upon local experience in the various states. Hence it is up to every physician to heed closely and diligently the advice recently issued by the Society's veteran committee on medical defense and grievance. It is the individual doctor's problem.

On a broader base we may look forward to fostering the principle that the only way to reduce malpractice frequency is not to allow the carrier to settle the claim as a nuisance suit, but instead to force the unjust case into court no matter what the expense or inconvenience to the individual doctor. Such vigorous action would certainly have a decided influence in the problem of threatened suits.

DOCTORS AND HOSPITALS

Elsewhere in this issue will be found a paper under this title delivered before the Rhode Island Medical Society at its recent annual meeting by Dr. Philip D. Bonnet, Executive Director of Massachusetts Memorial Hospitals.

Its careful perusal is urged upon all. "Doctors and hospitals are being tested by the fire of public opinion. Out of the fire — will come greater strength." The philosophical implications of this simple statement of fact are neither apparent nor understandable at first glance. The many factors contributing to this opinionative combustion compel thoughtful analysis if the highly desirable goal toward which doctors and hospitals are striving for improvement in patient care to which we are eternally dedicated, is to be achieved without coercion, compulsion or even direction from without.

This column has previously pointed up some of the problems involved with possible solutions and remains ever alert to newer ideas relating to the ever increasing complexity of medical care.

As Dr. Bonnet so succinctly states: "No progress is made without creating new problems and finding solutions to them." Not always an easy task but one which presents a challenge to medicine's best intellectual as well as professional efforts. And therein lies a responsibility that each individual doctor must share.

Again, be exhorted to read this fine contribution to a more vital aspect of American medical life today.

THE OSTEOPATHIC ISSUE

As noted in the report of our Delegate to the A.M.A. House of Delegates, published in our July issue, the report of the committee for the study of the relations between osteopathy and medicine evoked much spirited discussion. The reference committee of the House, after a lengthy hearing on the report, stated that in its opinion the study report was a splendid and constructive accomplishment, and one that requires complete knowledge, time and very careful consideration in order that no mistake may be made in any recommendations concerning it.

The recommendations made by the special committee included the following:

1. That the House of Delegates declare so little of the original concept of osteopathy remains that it does not classify medicine as currently taught in schools of osteopathy as the teaching of "cultist" healing.

2. That the House of Delegates state that pursuant to the objectives and responsibilities of the American Medical Association which are to improve the health and medical care of the American people, it is the policy of the Association to encourage improvement in undergraduate and postgraduate education of doctors of osteopathy.

3. That the House of Delegates declare that the relationship of doctors of medicine to doctors of osteopathy is a matter for determination by the state medical associations of the several states and that the state associations be requested to accept this responsibility.

4. That the Committee for the Study of Relations between osteopathy and medicine or a similar committee be established as a continuing body.

While the reference committee of the House of Delegates held the position that the recommendations are sound, it wisely noted that no emergency exists, and therefore it favored the recommendation of the Board of Trustees that action on the report be deferred until June 1954.

In the meantime it is suggested that the members of the House be prepared to answer the following questions:

1. Should modern osteopathy be classified as "cultist" healing?

2. Since the objectives of the American Medical Association include improvement in undergraduate and postgraduate education, should doctors of medicine teach in osteopathic schools?

3. Should the relationship of doctors of medicine to doctors of osteopathy be a matter for determination by the several state associations?

As was brought out in the hearings, the different states have adopted varying types of legislation as regards osteopathy. The Rhode Island statutes have been most liberal, now allowing osteopaths to prescribe drugs, and under special qualifications to perform major surgery. Other state statutes are most restrictive. This lack of uniformity in basic licensure poses a tremendous problem for the House of Delegates to establish broad patterns national in scope. Undoubtedly the issue will come in for much discussion and careful review in each of the states in the coming months.

INTERPROFESSIONAL RELATIONS

During the past year Doctor Jackvony, our immediate past president, made a strong effort to form an interprofessional council whereby prob-

continued on next page

lems of mutual interest to the various professions might be discussed. A meeting to explore the possibility of the proposal was held, but the failure of some of the groups to follow through on the idea has resulted in its temporary shelving.

Meanwhile our Society has gone ahead to develop stronger liason with the other professions in the past few years. The State Nurse's Association and the State Dental Society have been particularly cooperative in working out problems involving health and welfare in our communities calling for physician assistance. During the year the committee on medical-pharmaceutical relations met with representatives of pharmacy and the meeting of minds has set the pattern for further conferences to bring about a better understanding between physicians and pharmacists.

In April the first meeting with the Rhode Island Bar Association was held. In fact it was the first joint assembly between doctors and lawyers since the Rhode Island Medico-Legal Society fell a victim to the wartime elimination of meetings. Certainly the enthusiastic response to the medical-legal assembly indicates that we may readily develop a deeper understanding of our legal problems, particularly as regards the appearance of the physician in court.

In this issue a splendid interpretation and explanation of the reasons why medical experts disagree is ably set forth by our Dr. John E. Donley who made the same presentation at the opening of our joint meeting with the legal minds of Rhode Island last April. This dissertation warrants the attention of every physician and lawyer.

Thus, though Doctor Jackvony's idea of a single clearing body for the professional groups awaits formation, the ground work is being well laid through the committee associations that the Rhode Island Medical Society is developing. There is an old law maxim that "the principal part of everything is the beginning." A good beginning has been made in fostering interprofessional relations; we look to its expansion in the years ahead.

MIDSUMMER MADNESS

The temperature has been in the 90s for several days. It's not quite so hot today, but it is terribly sultry—it makes us see things. In the bulletin of a big insurance company we see that in three years of war there have been about 32,000 killed in Korea. Nervously jumping over to the last page of the bulletin we find that there were 38,000 killed here at home by automobiles in just the past year.

Then we remembered that we had read the bulletin of the American Medical Association which points out that physicians should proffer advice to patients "who they believe should not operate a motor vehicle." It tells many conditions under

which people should not drive cars; those who have just received an anaesthetic or have taken certain drugs or have severe heart disease or epilepsy. The most important group of all, in our estimation, are "those with mental instability." We would most certainly like to take this last group off the road, for it is evident to us watching driving habits that they comprise a large portion of the automobilists.

Having disposed of these dangerous persons we would turn our attention to the designers of automobiles. We can't go off the main highways in our latest car because it is so low slung that we hit any moderate bump in the road. We are told that cars are built thus so that they will be more stable. The insurance bulletin tells us that during the time in which this change has been made that 40 per cent more cars overturn on the road than at the beginning of the period. The heat is certainly befuddling us.

We used to enjoy riding through the country on roads that meandered about a bit and were bordered by pleasant foliage. Wherever we go now the trees have been hacked down and long, raw gashes of high speed roadway push straight ahead as far as the eye can reach. We are told this was done because curves are dangerous, and the drivers run off the road. Again the insurance bulletin tells us that there is a 40 per cent increase in deaths because of cars running off the roadway.

The same medical bulletin sent out to the newspapers give the public medical information which we doctors have not received yet in our JOURNAL, a week later. A case is reported of one child who died after eating poisonous berries in a city park. A goodly proportion of the plants growing in our gardens and public parks are poisonous; belladonna, aconite or monkshood, digitalis or foxglove, etc. On the whole though we do not think that our parks and gardens should be too much despoiled. The children are thousands of times safer there than on our roadways.

The same bulletin tells the public that there is a drug with a trade mark name that has been used in two cases of excessively rapid beat of the upper part of the heart, with normal heartbeat following. The bulletin goes on to say "If further experience confirms its safety it may prove to be the drug of choice." Irritated as we are by this summer weather we peevishly think that until "further experience confirms its safety" the public had better not be told about it.

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SEARLE *Research in the Service of Medicine*

LOW BACK PAIN*

EDWARD H. CROSBY, M.D.

The Author, *Edward H. Crosby, M.D., of Hartford, Connecticut. Chief, Orthopedic Service, McCook Memorial Hospital, Hartford, and at Veterans' Home and Hospital, Rocky Hill, Connecticut.*

A FEW YEARS ago a painful belly was in the same category that the low back pain is today. The surgeon by study and research had improved the methods of diagnosis of the acute abdomen so that at the present time very few errors are made. If as much time is spent on the study of the individual with low back pain the answer to its cause can be found. A careful history should include the details of an accident, the onset and progress of the symptoms, the cause of the aggravation and relief, the symptoms at the time of onset and at the present time, the response of the symptoms to activity, heat and rest, and the details of previous treatment. The past history of previous accidents, operations and serious illnesses is important and throws light on pre-existing back conditions. A review of the anatomical systems helps in discovering chronic infection or previous trouble which may be forgotten unless specific questions are asked. The physical examination with the patient completely disrobed includes inspection of gait, activity, posture, musculature, chest expansion, list, pelvic tilt, scoliosis and lumbar lordosis. The examination should follow a definite routine and should include the observation and motion of each and every joint from the temporomandibular joints to the joints of the toes. Palpation discloses tender points, muscle spasm and tumor or swelling. The extremities are measured for length and size and the circulation especially of the feet recorded. There are many special tests used to show abnormality or disease of the lower back. I use only two of these tests in the routine examination of the back, the straight leg raising or Laseque test and the straight leg raising with the foot dorsiflexed or Bragard's test. When there is muscle spasm of the lumbar muscles the spasm can be further tested by placing the examining thumbs one over each lumbar region and asking the patient to walk. The lumbar muscles on the side which supports the weight should relax and cause

muscle tightness, which is not spasm, to disappear.

Name Tests Explained

For the purpose of completeness I will list and explain the various name tests as listed by Lewin. The Lewin test is performed while the patient is standing with his back to the examiner. The patient is asked to bend forward and touch his toes which usually causes the knees to flex. The examiner forces first one and then the other knee into complete extension. These movements may be accompanied by pain in the lumbosacral, sacro-iliac, and gluteal regions. This test is helpful in localizing the back lesion. The Neri Bowing test is done with the patient standing. He is asked to bow and the test is positive if the knee on the affected side is flexed. If a patient is relieved of backache when he sits, it means that relaxing the hamstrings gives him relief and indicates a pelvic rather than a lumbar lesion. The Goldthwait test is done with the patient supine and both legs on the table. The affected leg is flexed on the abdomen with one hand while the other hand is placed under the lumbar spine. If pain is caused by this motion the hand under the lumbar spine can determine what part of the spine is moved at the time the pain begins and the lesion thus localized. The Laseque or straight leg-raising test is positive when, with the knee extended, flexion of the thigh is markedly limited or causes pain. The Laseque contralateral sign is positive when raising the leg causes pain on the other side. I have mentioned the Bragard's sign above. In the Lewin test the patient is asked to sit up from the supine position while the examiner gives counterpressure on the legs. With lumbar arthritis or sciatica he is unable to do so and indicates the area of his back made painful by the movement. Lindner's sign is produced by forced passive flexion of the head on the chest and is positive if pain is produced in the lumbar region and in the sciatic nerve distribution. The Soto-Hall sign is similar to the Lindner sign and is helpful in the diagnosis of vertebral injuries. The examiner places one hand on the sternum and with the other hand flexes the head on the sternum. The pull of the posterior ligament causes pain at the injured vertebra. The Smith-Petersen test is a special application of the straight leg raising test. The examiner's free hand is placed under the sacrum and if pain is produced before the lumbar spine starts to

*Presented before the Rhode Island Academy of General Practice at the Rhode Island Medical Society Library, at Providence, R. I., April 23, 1953.



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LOW BACK PAIN

continued from page 450

move a lesion of the sacro-iliac joint is indicated. The Fabere-Patrick test is performed with the patient supine. One external malleolus is placed on the opposite knee and the flexed knee depressed. If pain is produced a lesion in or around the hip is indicated. Laguerre's test is carried out with the patient on his back. The thigh and knee are flexed and the thigh is abducted and rotated outward. The production of pain is indicative of a lesion of the hip joint, iliopsoas muscle spasm or a sacro-iliac lesion. In the Gaenslen test one leg is flexed forcefully on the abdomen and held by the patient while the other leg is hyperextended over the edge of the table. This test indicates the side as well as the joints involved by the location of the pain produced. Lewin modifies the Gaenslen test by having the patient on the side. The Ely Heel-to-Buttock test is made with the patient prone. The heel is forced to the buttock and when positive the pelvis and lumbar spine is raised from the table. This indicates a lumbosacral lesion or a tight fascia lata. The Nachlas Knee-flexion test is done in the same manner as the Eli test. A positive test indicates disease present in the lower back and indicates the joint involved. The Pitkin prone knee flexion test, the Yeoman test and Mennell's test are further tests on the prone patient and indicate sacro-iliac disease. The Ober test is done with the patient on his side. The thigh on the table is flexed enough to obliterate the lumbar lordosis. The upper leg is flexed so that the knee is at a right angle, the upper leg is then abducted and extended. The test is positive if the leg remains abducted and indicates a tight ilio-tibial band.

A rectal or vaginal examination should be done to complete the orthopedic examination.

Roentgenograms of the low back should include the lower dorsal, lumbar and lumbosacral spine with antero-posterior, lateral and oblique views. Such an examination has a positive as well as a negative value. The interpretation should be made by a roentgenologist. Further laboratory tests should be done as indicated to rule out infection, thyroid disease, blood abnormalities, and changes in blood phosphorus, phosphatase and proteins.

Knowledge of the embryology of the spine, the anatomy of the vertebral column with the musculature of the back and the mechanical principles of the function of the back are essential. The back is a complicated mechanical machine and functions normally without pain, if all its intricate parts are intact and in balance. You can remember the anatomy course during the first year in medical school. The lower back was the last part of the cadaver to be dissected, if at all. It was studied last and I am sure was the least understood.

RHODE ISLAND MEDICAL JOURNAL

The spinal column as described by Keith is approximately 71 cms. in length in the human male and 61 cms. in the female. In about 90 percent of men there are seven cervical, twelve dorsal or thoracic, five lumbar, five sacral and four caudal vertebrae making thirty-three in all. In the remaining ten percent there is some departure from the normal arrangement and these departures affect certain definite regions. The regions affected are those which lie at the junction of one section of the spine with another: at the cervico-dorsal, dorsolumbar, and the lumbo-sacral junctions. In ninety-five percent of men the twenty-fifth vertebra forms the first sacral segment, in one percent the twenty-fourth, and in three percent the twenty-sixth. Because of these variations many developmental variations in the form and the architecture of the vertebra are found in these regions.

Willis has described the lumbosacral joint as follows: There are three articulations between the last lumbar vertebra and the sacrum, an amphiarthrodial joint between the corresponding vertebral bodies, and two diarthrodial joints between the articular processes of the vertebral arches. The bodies are united by thick, powerful, wedge-shaped, intervertebral fibrocartilage, and by prolongations of the anterior and posterior longitudinal ligaments of the spinal column. A number of ligaments connect the vertebral arches and their processes, namely the ligamenta subflava between the laminae, and interspinous and supraspinous ligaments between spinous processes, while the articular processes on either side are connected by articular capsules and synovial membranes. The interspinous and supraspinous ligaments are rather indefinite structures, but the ligamenta subflava are strong and elastic, since they contain a considerable proportion of yellow elastic tissue. In place of the usual intertransverse ligaments, two special lateral lumbosacral ligaments are developed; each is somewhat fan-shaped and is attached above to the inferior border of the transverse process of the last lumbar vertebra, while below it spreads out to become attached to the ala of the sacrum close to the sacro-iliac articulation, where it blends with the anterior sacro-iliac ligament. An inconstant band of fibers extends between the front of the sacral ala and the inferolateral aspect of the last lumbar vertebral body. Another specialized ligamentous development is the iliolumbar ligament, which extends from the last lumbar transverse process to the inner lip of the iliac crest, where it is attached for about two inches immediately anterior to the iliac auricular surface. Occasionally this ligament gains an additional weak attachment to the transverse process of the fourth lumbar vertebra, and it is really a specially thickened part of the lumbodorsal fascia. The lateral lumbosacral and iliolumbar ligaments are fre-

quently described together as the lower and upper parts of the iliolumbar ligament.

In addition to the ligamentous ties, adjacent muscles perform the function of powerful elastic ligaments. Their distribution, however, is remarkably unequal. Large masses such as the erector spinae and the psoas major muscles are lying posteriorly and laterally, while the anterior aspect which needs protection most is uncovered, and unprotected by muscles. Other muscles of less power and importance such as the multifidus, quadratus lumborum, the interspinous and intertransverse muscles also assist in binding the bones together. By virtue of their postural tonus all these muscles are of great importance in maintaining stability at the lumbosacral junction. The flexors of the spinal column are the abdominal muscles which are placed at some distance anterior to the lumbosacral spine.

The lumbosacral joint is located between the fixed pelvis and the movable lumbar spine. It is the lowest part of the movable spine and for this reason is subject of considerable mechanical strain. The assumption of the erect posture by man occurs in a large part in the lower lumbar region and thus additional strain has been added to the lumbosacral junction. A variety of mechanical weakness occur in the lumbosacral spine which are rare in other parts of the spine and so we have three basic factors which account for the very common symptom of lame back.

Pain in the lower back may be considered as primary if it originates in or around the bones, joints, ligaments, muscles, fascia, nerves or blood vessels or the lower back. Pain in the lower back may be considered as secondary if it is produced by or in extra spinal structures and referred to the back through the nerves by reflex or by mechanical transmission as by flat feet, deformity of the knees, or by pelvic tilt.

I like to think of the lower back as a complicated machine made of many mechanical levers and motors which must be in the state of equilibrium or balance to function smoothly without pain.

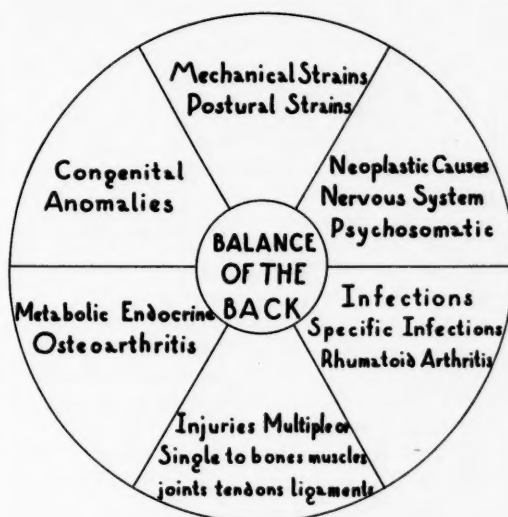


FIGURE I

Figure I: this diagram depicts the idea of balance. There are six basic types of disturbances which can affect the balance of the back: 1. Congenital Anomalies, 2. Neoplastic, nervous system abnormalities, and psychosomatic causes, 3. Metabolic and endocrine causes, 4. Infectious causes, 5. Injuries multiple or single. 6. Mechanical or postural.

Figure II: lists the congenital variations which occur at the lumbosacral junction which may cause the balance of the back to be broken resulting in low back pain. Spina bifida occulta and sacralization of the transverse process are the most common variations. All of these variations predispose an individual to low back pain but in most cases are not the instigating cause of the pain. A minor injury or strain, poor posture, muscle relaxation, or a disease process causes the onset of symptoms. The mechanical weakness of one or more of these variations prolongs the pain which does not respond to conservative treatment.

The medico-legal aspects of lumbosacral strain superimposed upon a congenital variation cause confusion because one group of medical experts testify that these anomalies and variations are insignificant while another group asserts that they are all important. The truth is that these variations render the lumbosacral spine more vulnerable to stress and strain. The recovery following an injury is delayed and a chronic type of back disability develops which is unresponsive to conservative treatment.

Defects in pars interarticularis of the neural arch separates the lower articular process and the spinous process from the rest of the neural arch which carries the upper articular process. Such defects

continued on next page

CAUSE OF LOSS OF BACK BALANCE

Congenital Causes

- Defect in neural arch spondylolisthesis.
- Variation in spinous processes
 - Spina bifida occulta.
 - Impingement of spinous processes.
- Elongation of transverse process butterfly type articulating with ilium.
- Lumbarization of first sacral vertebra.
- Sacralization of fifth lumbar vertebra.
- Variation in articular facets.
- Variation in lumbosacral angle.

FIGURE II

may occur on one or both sides of the neural arch and are most commonly found in the fifth lumbar vertebra although the fourth lumbar vertebra and the first sacral segment may occasionally be involved. This defect in the pars interarticularis was believed to be a congenital variation caused by two separate centers of chondrification and ossification which did not unite in the normal growth process. The condition has rarely been found at birth or in the fetus, becomes gradually more frequent as childhood advances, and is found in five to eight percent of the adult population. When such defects occur, the last lumbar vertebra has no firm hold on the sacrum and its body may slip forward carrying with it the entire spinal column. In a considerable number of these cases, the symptoms of pain in the lower back with or without sciatic radiation develops after injury and the defect in the pars interarticularis is believed to be caused by a fracture. In my experience, the severity of the pain caused by the forward slipping of the vertebra is in no way proportional to the extent of the slipping. This condition or anatomical variation is called spondylolisthesis. The pain in this variation is produced by the stretching of the anterior spinal ligaments, by pressure on the nerve roots from behind forward, and by the protrusion of the intervertebral disc which is frequently ruptured. The best treatment for spondylolisthesis is the operative removal of any tissue pressing on the nerve structures combined with a fusion of the lumbar spine to the sacrum.

Sometimes there is no defect in the neural arch and the whole vertebra including the spine and the neural arch is displaced forward. Junghanns, in 1930, called this condition pseudospondylolisthesis. The etiology of the lesion is an increase in the angle between the pedicle and the inferior articular facet which is normally ninety degrees. When the angle approaches one hundred and eighty degrees the increased strain gradually produces degeneration of the intervertebral disc which allows the forward slipping. This condition usually occurs between the fourth and the fifth lumbar vertebra and the average displacement is six millimeters. This amount of slipping is sufficient to cause back pain with or without sciatica.

Elongation of the transverse process of the last lumbar vertebra may be present on one or both sides. When present on both sides and the process is of sufficient length to articulate with the ilium, the lumbosacral structure is usually stable and does not cause pain. Arthritic changes often occur in the pseudo-joint made by the transverse process resting on the ilium. This arthritis does cause pain. When the elongated transverse process is present on only one side the lumbosacral structure is not stable, the back is not in balance, and back pain occurs.

The body of the vertebra arises from two growth centers. Lack of formation or cessation of growth of either of these centers results in an absence of one-half of the vertebral body. Deformity develops as the vertebrae above gravitate downward on the side of the missing portion. If the spine is unstable as indicated by increasing curvature or any other deformity during adolescence, a fusion of the involved vertebrae should be done.

Spina bifida is a condition in which the neural arch does not form and may consist of the single absence of the spinous process of the last lumbar vertebra or the first sacral segment. The laminae may be narrow or deformed, short with a gap between them in the midline, or absent altogether. A posterior gap is very common in the first sacral segment and is often not even reported by the roentgenologist. It is less often seen in the last lumbar vertebra and when present causes an unstable lumbosacral structure. Occasionally the lumbar spine is wide open posteriorly allowing the meninges to herniate. The herniation of the meninges is called a meningocele and if the nerve roots are also herniated it is called a meningomyelocele. No treatment is indicated for the spina bifida unless the lumbar spine is unstable. When a meningocele or meningomyelocele occurs the condition is neuro-surgical as well as orthopedic.

The articulations of the lumbosacral spine normally lie in the sagittal plane. The superior articular facets face backward and inward, the inferior facets face forward and outward. Occasionally the facets at the lumbosacral junction are diminutive or face anteroposteriorly, obliquely, or are not symmetrical. Such joints cause an unstable condition of the lumbosacral junction, cause the loss of back balance and pain.

Occasionally the spinous process of the fourth lumbar vertebra is large, long, and touches the spinous process of the fifth lumbar vertebra. This may also be caused by an extreme lumbar lordosis. The touching spinous processes form a pseudo-joint subject to traumatic arthritis and pain.

CAUSE OF LOSS OF BACK BALANCE

Metabolic endocrine and degenerative causes.

Nutritional disturbances; obesity, leanness.

Rickets, Paget's disease, gout, arteriosclerosis of aorta, osteoarthritis, osteomalacic, hyperparathyroidism, hyperthyroidism, osteoporosis with or without fractures, acromegaly.

Circulatory causes: ischemic backache, hemorrhage and, hematoma.

FIGURE III

Figure III: metabolic and endocrine disturbances affect the whole body generally and certain of these diseases involve the skeletal system in a specific and characteristic manner. Rickets is a systemic disturbance of metabolism due to a deficiency in vita-

min D which causes imperfect calcification of osteoid tissue. The phosphorus and calcium in the blood are lowered, the bones become soft, and deformities develop about the epiphyses of the extremities, the thorax and the back. The disease occurs between the sixth and the twenty-fourth month of infancy but the deformities which take place unless corrected remain thru life. In older children a condition of renal rickets in which the calcium metabolism is disturbed by a kidney abnormality affects the skeletal system producing pain. Gout, acromegally, hyperparathyroidism, hypoparathyroidism and hyperthyroidism should be considered in the diagnosis of obscure low back pain. Paget's disease, the cause of which is unknown, may affect the bones of the pelvis and the spine. Obesity may be an endocrine disease and although the osseous structure is not involved the large abdominal weight places an excess strain on the lower back and can of itself cause back pain. The diagnosis in these cases is made by means of the history, the physical examination, roentgen ray examination and special laboratory examinations. The treatment for the local symptoms in the back is in general the same as developed for the specific disease plus supportive treatment for the back.

Osteoporosis secondary to senility, trauma, infection and glandular disturbances and osteomalacia in which condition the bones become soft and flex-

ible have a predilection for the vertebrae. Compression of the vertebra occur resulting in shortening of the trunk with kyphosis. Very mild trauma as sitting down hard may cause a compression of the vertebral body and pain. The diagnosis is chiefly concerned with the cause of the osteoporosis and osteomalacia. The treatment consists of adequate dietary regime, adequate support for the back and routine health measures. Phemsiter and Sherman showed that the osteomalacia of the vertebrae could be slowly corrected by massive doses of estrogenic substance but when the treatment was discontinued the condition recurred. Combinations of the male and the female hormone are now being used to cause recalcification with questionable results.

I do not wish to discuss degenerative (hypertrophic, osteo-) arthritis at this time except to include it in this list of degenerative diseases of the spine. This type of arthritis is more common in the laboring person and indicates a wearing out process in the vertebral joints. The usual changes are osteo-cartilaginous proliferations about the margins of the vertebrae, and fibrillation and irregularity of the articular cartilages. Although degenerative arthritis may occur at any age due to injury or excess strain, it is generally associated with age and a large majority of persons over fifty years old have degenerative changes in the dorsal or lumbar spine. If the cartilage of the normal joint

continued on page 458

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LOW BACK PAIN

continued from page 455

is subjected to severe injury or to repeated mild trauma due to the incongruity of the joint surfaces or abnormal function, a condition similar to degenerative arthritis develops.

CAUSE OF LOSS OF BACK BALANCE

Neoplastic causes: primary, metastatic, benign malignant

Nervous system causes destructive or traumatic lesions, psychosomatic causes as hysteria, malingering.

Hematological causes: anemias, leukemias.

Thoracic causes: pleural adhesions, pneumonia and empyema, tumors, aneurysms, coronary disease

Abdominal causes: visceral disease, retroperitoneal abscess, tumors, aneurysm, kidney lesions.

Urological causes: prostatitis, lesions of bladder ureter, kidney.

Gynecological causes: inflammatory, mechanical, neoplastic.

Obstetrical causes: mechanical, postural.

FIGURE IV

Any type of tumor may occur in the vertebrae, the most common are: metastatic carcinoma, hemangioma, osteitis fibrosa cystica, myeloma, chondroma, osteoma and sarcoma. A history of malignancy elsewhere in the body is helpful in making the diagnosis and biopsy of the vertebral bone lesion must be employed to make a diagnosis in obscure cases. Biopsy of a vertebral body is difficult but many times worth while. A back pain which does not respond at least in some degree to conservative treatment brings up a possible diagnosis of malignancy. A deferred diagnosis may sacrifice the patient's life while a mistake in diagnosis results in needless surgery or the needless loss of a limb. The various methods of treatment of vertebral tumors include: roentgen ray, radium therapy, curettage, resection and bone graft, braces, casts, transfusion, calcium, vitamin D, frames, traction, opiates, chorodotomy and rhizotomy.

Nervous system causes of back pain include such conditions as neuritis, radiculitis, meningitis, encephalitis, arachnoiditis, poliomyelitis and Herpes Zoster. The term neuritis as a diagnosis is probably misused more often than any other term in medicine.

The low back, being a very vulnerable structure to strain and injury, is often the seat of psychosomatic manifestations. Many who injure their backs while at work or in an accident in which insurance is involved tend to exaggerate their symptoms to justify their claims. In most cases this exaggeration is not willful but a very human and subconscious reaction. An emotional instability plus a back injury may develop into a difficult traumatic neurosis. Even a well-meaning worker might have difficulty in dissociating his actual symptoms

RHODE ISLAND MEDICAL JOURNAL

from symptoms born of a conscious or subconscious desire to obtain what he thinks is his due for an injury. Malingering is the simulating of a disease or a disability and is dishonest. Many times it is very difficult to distinguish between unconscious exaggeration, neurosis and malingering. I have always made an effort to be the patient's doctor and I know that I have been completely taken in. I was asked to see a man who had injured his back in a fall. My history and examination left no doubt in my mind that he had had a severe injury and x-rays showed a compression of one of the lumbar vertebral bodies. The compensation commissioner awarded him a permanent disability and the case was closed. A few weeks later the same fellow was sent to me completely free from symptoms for a pre-employment examination. This man had to sign a complete waiver on his back. During the last war, I had one ward completely filled with sailors and marines with back pain. I kept them at complete bed rest with a twenty-four hour watch to make sure that they stayed in bed. Every effort was made to make a diagnosis, adequate treatment was given and each man's back was examined daily. Those men in which a diagnosis could not be made and who had no relief of the back pain were placed under our psychiatrist. Very few malingerers were discovered but many hysterical and neurotic disorders were found. I firmly believe that there are very few true malingerers.

Anemias, leukemias and Hodgkin's Disease may produce pain, tenderness, and limitation of motion of the back very similar to those of arthritis of the back. The diagnosis is made through laboratory examination and biopsy examination.

The thoracic causes of backache can be listed as fracture of ribs, pleural adhesions, pneumonia and empyema, tumors, aneurysms, sequelae of rib resections or thoracoplasty. I will never forget a man whom I saw with very severe low back pain. X-rays of the back showed very extensive degenerative spurs in the dorsal and lumbar spine and it seemed that these spurs were the cause of the pain. However, a complete medical investigation was done. The blood pressure was lower than seemed normal and the electrocardiograph showed a mild left axis deviation. A few days' rest in bed with heat to the back and medication for the pain relieved all the symptoms and the patient was allowed to return to his normal activity. The following week the back pain recurred but was much more severe than at first. The patient was hospitalized and an internist called in consultation. The man died in a few hours. The cause of death was coronary thrombosis. I'm sure that the low back pain was caused by the coronary disease.

Any disease of the genito-urinary system may cause back pain. The most frequent cause in the

continued on page 460



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LOW BACK PAIN

continued from page 458

male is infection of the prostate. I have heard a urologist say that five percent of men with low back pain can be cured by clearing up a prostatitis. This may or may not be true but it indicates that a rectal examination must be done on every man with low back pain.

The most common obstetrical causes of backache are mechanical, postural, metabolic, and ligamentous strains before, during and after delivery. Months after delivery poor posture secondary to weak abdominal muscles is a very important factor in the production of back pain.

CAUSE OF LOSS OF BACK BALANCE

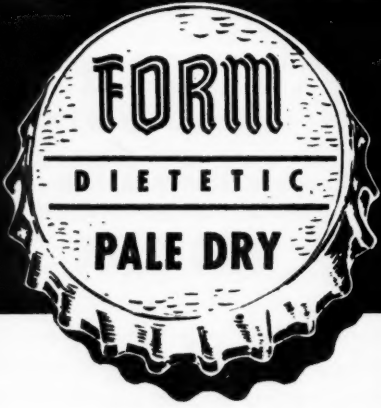
Infectious causes: acute or chronic infections, local infection arising from foci or generalized.

Specific infection: rheumatoid arthritis, spondylitis deformans, epiphysitis, osteomyelitis, tuberculosis, syphilis, anterior poliomyelitis, meningitis, fibrositis, fasciitis,

Infections of nervous system: neuritis, radiculitis, meningitis, encephalitis, arachnoiditis, poliomyelitis, brain abscess with meningitis herpes zoster.

FIGURE V

Infectious causes of back pain include acute or chronic infections, local infections arising from distant foci, generalized infections, and specific infec-



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tions. The specific infections include rheumatoid arthritis, spondylitis deformans, epiphysitis, osteomyelitis, tuberculosis, syphilis, typhoid fever, anterior poliomyelitis, meningitis, fibrositis, and fasciitis. I have seen two cases of brucellosis in which there was destruction of a lumbar vertebral body. A body cast was used for the local treatment of the back and the brucellosis responded to medical treatment. The lesion in the bone healed.

Rheumatoid arthritis of the spine is a frequent cause of back pain. All classifications of arthritis recognized the rheumatoid type as the infectious type or atrophic type of arthritis. The etiological factors, precipitating factors and pathological changes have been discussed since the time of Hippocrates. Strumpell-Marie type of rheumatoid arthritis occurs in young adults and affects chiefly the spine, the hips and the shoulders. The Bechterew type affects the spine with stiffening and ankylosis similar to the Straumpell-Marie type but is associated with nerve root symptoms and a paretic condition of the muscles. I believe that rheumatoid arthritis is a disease of the entire body with manifestations locally in various joints. It is difficult to make the diagnosis early unless the patient is hospitalized for the purpose of very complete laboratory and x-ray investigation. The treatment is also made easier and more effective because the whole patient must be treated generally as well as locally.

CAUSE OF LOSS OF BACK BALANCE

Traumatic causes: severe single or multiple minimal injuries, fractures of vertebral bodies pedicles, laminae, facets, traumatic epiphysitis, fracture-dislocation, spondylosis, spondylolisthesis.

Injuries to intervertebral disc: narrow of disc space, protrusion of disc, rupture of nucleus.

Injury to ligaments: tear of ligaments, hypertrophy of ligamentum flavum, tear of fascia, sprung back (Newman).

Injuries to muscle: rupture, hematoma, adhesions; compression, adhesions, concussion to nerves; injuries to skin; foreign bodies in back.

FIGURE VI

The traumatic causes of back pain include severe single injury or multiple minimal injuries. Fractures of the vertebral body, pedicles, laminae and articular facets follow severe traumatic force and the diagnosis is made by x-ray examination. In general the extent of the damage to the bone and the soft tissues determines the type of treatment indicated. Usually immobilization is the method of choice but it is wise to remember that the longer the immobilization is used the longer will be the period of rehabilitation.

The differential diagnosis of the cause of low back pain with sciatic radiation is between rupture of the intervertebral disc and all other causes.

continued on page 462

impetigo

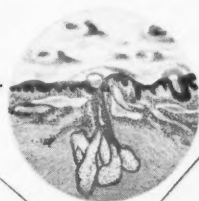


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LOW BACK PAIN

continued from page 460

Injuries to the intervertebral disc may occur between any two vertebral bodies in the spinal column. The protrusion of the disc substance must be secondary and follow a ligamentous tear or ligament degeneration. Protrusion of the disc substance may occur at any point in the disc circumference but to cause the classical syndrome of low back pain with sciatic radiation the protrusion must be adjacent to and press on the corresponding nerve root. Barr pointed out that the symptoms produced by the nerve root pressure correspond to the direction of the pressure on the nerve as well as the amount and duration of the pressure. The list of the back in this syndrome may be away from the side of the back affected if the nerve root is pressed upon from the lateral side and toward the affected side if the nerve root is pressed upon the medial side. A locally tender point is usually found over the nerve root involved and pressure over this point usually causes the typical radiation of pain with numbness and weakness in the involved leg. It has been shown that a pressure of fifteen hundred pounds per square inch may be produced in the nucleus pulposus between the fourth and fifth lumbar vertebrae. This tremendous pressure against the articular surface of the vertebral body may fracture the vertebral plate causing back pain without sciatic radiation. Over ninety-five percent of the total cases of protrusion of the intervertebral disc which cause symptoms occur in the lumbar spine between the fourth and fifth lumbar vertebrae and the fifth lumbar vertebra and the first sacral segment. These lesions may cause low back pain alone, sciatic pain alone or both back pain and sciatic pain. The back pain may begin insidiously without recognized injury or the patient may give a history of injury or strain to the back with sudden onset of symptoms. The typical lesion usually causes unilateral low back pain with associated pain radiating into the buttock on the affected side and down the lateral or posterior aspect of the thigh to the back

RHODE ISLAND MEDICAL JOURNAL

of the calf, the heel and the foot. Occasionally the pain is bilateral with bilateral radiation. The pain is often associated with numbness and weakness in the leg and is aggravated by coughing, sneezing, bending or lifting. As a rule examination shows muscle spasm of the lumbar muscles, a list of the back, and flattening of the normal lumbar curve. Motion of the back is restricted and painful and there is localized tenderness over the lumbosacral area of the affected side. The straight leg raising test is practically always positive on the affected side and if this test is not positive the presence of the ruptured disc is highly questionable. Rupture of the fourth lumbar disc is frequently accompanied by hypesthesia in the area of the fifth lumbar dermatome which is roughly the lateral side of the calf, the medial side of the top of the foot and the great toe. If the fifth lumbar disc is ruptured, there is usually hypesthesia in the area supplied by the first sacral dermatome namely the outer aspect of the foot and the heel and there may be weakness or loss of the ankle jerk. Roentgenograms may show straightening of the lumbar curve, narrowing of the disc space, scoliosis and hypertrophic changes of the adjacent vertebrae. The roentgen examination also helps to rule out other lesions of the spine, pelvis and adjacent structures. Studies of the spinal fluid may reveal an increase in the protein but in at least half of the cases the total protein is normal.

The diagnosis of a rupture of the intervertebral disc should be made from the history and physical examination. The myelogram is gradually losing its diagnostic significance and is largely being used to localize the area of the disc rupture rather than to make the diagnosis of a disc rupture. Destructive lesions of the spine as malignant tumors, tuberculosis and osteomyelitis may simulate a rupture of the disc. Chronic arthritis, and other conditions as peripheral nerve tumors, polyneuritis, and Herpes Zoster may produce some or all of the symptoms of a rupture of the intervertebral disc.

The treatment of the patient with a rupture of an intervertebral disc depends largely on the consultant. If an orthopedic surgeon is consulted the treatment is conservative. If the conservative treatment fails operative removal of the protruding disc with spinal fusion is the method of choice. If a neurosurgeon is consulted, the treatment is operative removal of the protruded disc. The statistics of the Campbell Clinic show that ten percent have immediate surgery, twenty percent have surgical exploration after conservative treatment and seventy percent have conservative treatment alone. Barr has shown that spinal fusion following the removal of the protruded disc offers about fifteen percent more patients with lasting relief of pain. The removal of the protruded disc relieves the

continued on page 464

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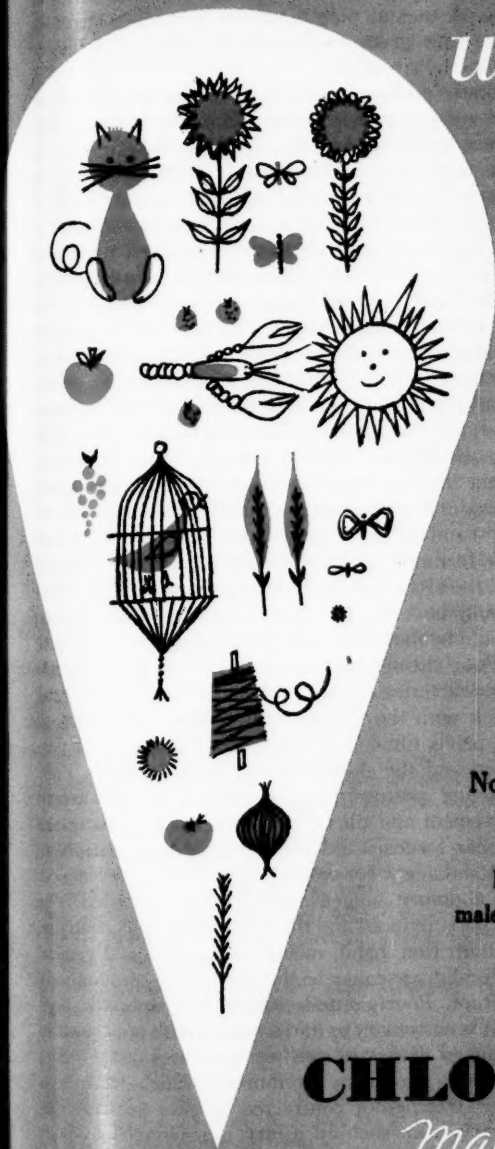
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LOW BACK PAIN

continued from page 462

sciatic pain and the spinal fusion relieves the back pain. Spinal fusion minimizes the disability from arthritic changes which eventually develop after most disc injuries and also reduces the number of cases with recurrent protrusion of disc substance in the same interspace. Fusion of the spine prevents further collapse of the intervertebral disc space.

Williams of Texas has described a condition in which the disc space between the last lumbar vertebra and the first sacral segment is decreased to such extent that the articular facet of the first sacral segment protrudes into and practically obliterates the adjacent foramen through which the nerve root passes. The nerve root is pressed upon causing sciatic pain. This syndrome responds to conservative treatment with support and exercises correcting the lumbar lordosis.

Tears of the posterior ligaments of the lumbar spine may occur in the normal back with extreme force with the back flexed or in the weak unstable back with minor force. This condition is termed a "sprung back" by Newman. Such ligamentous injuries may heal with scar tissue or they do not heal at all and result in a badly disabled back. The affected vertebrae are unstable and the joints may subluxate when the vertebral column is flexed or extended. Pain occurs through the lower back with full flexion or when partial flexion is held for a long enough time to allow the erector spini muscles to become fatigued.

Injuries of the muscles of the lower back occur with hemorrhage and tears of the fascia. These injuries heal with scar formation, causing pain when the resultant scar is stretched or strained. This is the true myositis or fasciitis.

CAUSE OF LOSS OF BACK BALANCE

Mechanical Strains

Occupational Athletic or Postural
Scoliosis idiopathic or paralytic.
Inequality in length of legs.
Static deformity of feet.
Muscle paralysis or paresis.
Sequalae of operations as disc, removal without
spinal fusion Rib excision.
Sequalae of prolonged immobilization as pro-
longed bed rest.

FIGURE VII

The posture of man has been the subject of controversy and study for ages. Goldthwait pointed out that poor posture affected the entire body in health as well as in disease and that correction of faulty posture was essential in the treatment of any chronic illness. Normal body posture varies with the body type of the individual. The most easily understood nomenclature described by Goff has divided the body types into four groups. We have

RHODE ISLAND MEDICAL JOURNAL

the fat or endomorphic type, the muscular-balanced or average man type, the muscular or mesomorphic type, and the thin elongated or ectomorphic type. A mental picture of the normal posture in these four groups will make it easier to judge an individual's posture.

Static posture is inactive posture or posture at rest without anticipated action while dynamic posture as described by Howorth is posture in motion, in action, or in preparation for action. The lying posture should be one of ease and comfort permitting complete relaxation. The mattress should be soft but should not sag either from end to end or from side to side. The basic sitting posture should be with the trunk and head erect and centered over the pelvis or tilted slightly forward with a slight lumbar arch. The hips and knees should be flexed to ninety degrees. In the standing posture the body should be vertical and essentially straight when seen from the side as well as from the back. The vertical line should pass through the ear, shoulder, center of the hip, and center of the ankle when seen from the side. The thoracic and lumbar curves should be slight and the pelvis erect rather than tilted forward. The feet and the knees should be directed forward and the arches of the feet should not sag. The chest should be erect but not tense and the abdomen should be flat, relaxed and not sagging or retracted.

Poor sitting posture, as described by Howorth, is characterized by a drooping of the spine and the trunk with the thoracic and lumbar spine flexed, the pelvis tilted back, the abdomen and chest flattened and the shoulders and head forward. Poor standing posture is characterized by a forward movement and tilt of the pelvis with an increased lumbar lordosis and round upper back with head and shoulders forward. The knees become flexed, the abdomen sagged and the chest flattened. The height is reduced and the whole body sags. Fatigue, malnutrition, habit, mental depression and general or local disease may be the basic cause of poor body posture. Poorly fitted clothes and especially high

It is customary to find a person with poor posture living in moderate comfort until an injury occurs straining ligaments or muscles which have been over stretched or contracted by poor posture. Recovery from such an injury is prolonged by poor posture and the chronic lame back results. The posture factor is often the important cause of continued low back pain. Such low back pain continues until the poor posture is corrected.

A common source of imbalance of the back is an inequality of leg length. I had the opportunity to examine the posture of all the freshmen at Yale University during the year 1932. It was found that twenty out of every hundred had one leg one-half inch or more shorter than the other. This caused an inequality in the height of the hips and a corresponding scoliosis. If the difference in the length

of the legs is less than one inch the person does not limp and is usually not aware of the difference in the length of the legs. A minor injury to his back, however, may not recover and a chronic type of lame back results because of the mechanical postural strain of the low back.

A very common source of postural imbalance and pain in the lower back is found in poor posture of the feet. I have found very few patients with a normal foot stance. In the normal foot the weight is borne on the heel, the fifth metatarsal head and the first metatarsal head in the ratio of five, three and one. A downward movement of the medial longitudinal arch of the foot is attended with proportional changes in the entire weight bearing musculo-skeletal system. The downward movement of the longitudinal arch causes an inward rotation at the ankle and a corresponding medial displacement of the patella. These changes indicate that the entire leg rotates inward and the forward tilt of the pelvis is increased. Jones showed that the plane of the forward tilt of the pelvis can be decreased twelve to fifteen degrees by correcting the pronation of the feet. This correction of the pronation of the feet and the decreasing of the pelvic tilt has relieved many patients with a chronic low back pain.

I have tried to bring out some of the fundamental principles in the diagnosis and the treatment of the lame back. The subject is very complicated, and if I have helped to remove some of the confusion, I have fulfilled my purpose.

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DOCTORS AND HOSPITALS

concluded from page 445

and disability. We should be humble, accept our great blessings with thankfulness, and acknowledge our debt to the past. Doctors have voluntarily incurred a social debt by the special position and opportunities for education conferred on them by society.

In the words of Governor Herter of Massachusetts: "In the trying days ahead, as we struggle together with the problems of a complex modern society, may God give us the courage to accept cheerfully those things that we cannot change, the courage to fight to make changes where they are needed and the wisdom to know the difference—"

Doctors and hospitals are being tested by the fire of public opinion. Out of the fire in my humble opinion will come greater strength.

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ON THE MEDICAL LIBRARY BOOKSHELVES

Recent Accessions

The following titles have been added to the Davenport Collection through purchase and gift:

- L. H. Butterfield, editor — *Letters of Benjamin Rush*. 2 vols. Princeton University Press, 1951.
 Richard Gordon — *Doctor in the House*. Harcourt, Brace and Company, N.Y., 1953. Gift of Doctor Chase.
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BOOK REVIEWS

GIFFORD'S TEXTBOOK OF OPHTHALMOLOGY by Francis Heed Adler, M.D. 5th edition published by W. B. Saunders Company.

This book is primarily intended for the concern of the general physician. It is a result of the experience gained from five years of teaching undergraduate students in Ophthalmology using the fourth edition textbook.

RHODE ISLAND MEDICAL JOURNAL

The sections on hypertensive diseases and diabetes are considerably enlarged since this is the field of Ophthalmology of most concern to practicing physicians, and should be very useful for those who are called as consultants for these patients.

The previous sections on operations which describes the steps of various surgical techniques has been omitted and in its place the general indications for surgery are described.

The section on Glaucoma describes the newer concept of dividing the glaucomas into narrow angle and wide angle types, which most ophthalmologists now feel better explains this insidious and calamitous disease.

A good deal of new material in the field of therapeutics has been added in keeping with recent developments.

This edition is a very practical manual in instructing the general physician in what cases he may safely treat himself, how it should be done, and what cases should be referred to an ophthalmologist.

It is too bad that more of the fundus pictures in the section on the retina are not in color.

LEE G. SANNELLA, M.D.

DOCTOR IN THE HOUSE by Richard Gordon. 1st American ed. Harcourt, Brace and Company, N. Y. 1953. \$2.75

"A parcel of lazy, idle fellars, that are always smoking and drinking, and lounging . . . a parcel of young cutters and carvers of live people's bodies, that disgraces the lodgings."—Bob Sawyer's landlady in *PICKWICK PAPERS*.

This definition of a medical student appears on the title page of *DOCTOR IN THE HOUSE* and sets the mood for a very merry book. Doctor Gordon's "fellars," however, are neither lazy nor idle whether in the classroom or engaged in extra curricular activities. They are busy indeed, studying anatomy, surgery and obstetrics and the equally serious subjects of beer drinking and seduction.

The author's crisp, easy style carries the reader along entertainingly through the ups and downs in the career of an English medical student from his first interview with the Dean, through school and the terrors of qualifying examinations to his first, rather shaky, day as A Resident Physician.

The characters of the Top Brass at St. Swithin's are caricatured but this adds to the spirit of fun and frolic which pervades *DOCTOR IN THE HOUSE*.

HELEN DEJONG

INTERIM MEETING DATE . . .

Wednesday, November 18

TRAINING IN CHILD PSYCHIATRY AT THE BRADLEY HOME

The Council on Medical Education and Hospitals of the American Medical Association and the American Board of Psychiatry and Neurology have approved a residency program in Child Psychiatry at the Emma Pendleton Bradley Home, which is an associate member of the American Association of Psychiatric Clinics for Children. The program will provide for three appointments, each of one year's duration, preferably for those who have already had two years psychiatric training with adults.

The Bradley Home has a patient population of fifty children from four to twelve years of age, of both sexes and of normal intelligence, presenting psychoses, neuroses, behavior problems and convulsive disorders associated with emotional disturbances. In addition to the experience provided at the Bradley Home, the residents will participate in the various approved training programs now being carried on at the Home. These include: Clinical Psychology; Psychiatric Social Work; Psychiatric Nursing; Teaching of Exceptional Children; Pediatric Residencies.

In addition to the work at the Bradley Home, further experience will be provided by the Providence Child Guidance Clinic, the Rhode Island Juvenile Court, the Meeting Street School for

Cerebral Palsy, the Nursery and Elementary Schools in Providence and the Butler Hospital.

As the Bradley Home now offers an approved hospital residency training program, a residency here may count toward meeting the three-year training requirements of the Psychiatric Board for the general practice of psychiatry.

Requests for further information should be addressed to: Maurice W. Laufer, M.D., Director, Emma Pendleton Bradley Home, Riverside 15, Rhode Island.

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(continued from July issue)

LIBRARY

From March 29, 1952 to April 6, 1953 the library was consulted by a total of 2,066 visitors, of whom physicians numbered 1,039 and the general public 1,027. There were circulated 1,123 journals and 297 books. The number of periodicals and books consulted in the library is, of course, much larger, no separate count was made of these. 199 bibliographies were prepared during this period.

During the past year 284 different periodicals were received. Several of the new titles were gifts of members. From Dr. Malford W. Thewlis were received *Cancer*, *Cancer Research*, *Diabetes*, *Metabolism*, *Plastic and Reconstructive Surgery*; from Dr. Walter S. Jones, *Western Journal of Surgery*, *Obstetrics and Gynecology* (two-year subscription) and from Dr. Seebert J. Goldowsky, *Post-Graduate Medicine* and *The American Surgeon*. Additional new periodicals were added through exchange.

During the past year, the library was increased by 374 bound volumes, 45 of which were purchased by the Day Fund, 11 by the Davenport Fund, and 2 from the general accounts. 41 were received through the Rhode Island Medical Journal and 2 through the Medical Library Exchange. 159 volumes were received as gifts, and many unbound journals and pamphlets.

Our approximate number of bound volumes in the library now numbers 39,764, of which 27,830 have been catalogued. We have checked lists of duplicates offered by other libraries and through the Medical Library Association Exchange several gaps in our runs of important journals were filled.

During the past year we received many gifts. Of special interest is a gift by Dr. H. G. Partridge, *Puerperal Fever as a Private Pestilence* by Oliver Wendell Holmes, published in Boston in 1855, a rare item. Gifts were received from the following members: Doctors Beck, Chase, Corrigan, C. L. Farrell, Goldowsky, H. F. Hager, Hammond, Kramer, Partridge, Ronchese, Ruggles, Thewlis, Wilcox, Estates of Frank B. Littlefield and Louisa Paine Tingley. Gifts were received from the following non-members: Mrs. Minnie Ayers, Mrs. Mary D. Basso, Doctor Robert T. Beyer, Mrs. Benjamin C. Clough, Mr. John E. Farrell, Doctor A. M. Hellman, Mr. Wallace Maxon, Mr. Clifford B. Monahan, Doctor A. J. J. Rourke, Mr. Stanley H. Saunders, Doctor Ake Atenstedt and Doctor A. A. Werner, Abbott Laboratories, American Academy of General Practice, American Cancer

Society, Inc., American College of Chest Physicians, American College of Radiology, American Medical Association, American Proctologic Society, Association of American Physicians, Brown University Library, Chapin Hospital, Charles Pfizer & Company, Inc., Chicago Health Department, Chicago Medical Society, Duke University, Harvard School of Public Health, Health Insurance Council, Heyden Chemical Corporation, Institute for the Study of Analgesic and Sedative Drugs, International Poliomyelitis Congress, Kessler Institute for Rehabilitation, Life Insurance Association of America, M & R Laboratories, Medical Society of the State of Pennsylvania, Merck & Company, Inc., Metropolitan Life Insurance Company, Modern Medicine, National Foundation for Infantile Paralysis, National Vitamin Foundation, Providence Journal Company, Providence Public Library, Rhode Island Cancer Society, Inc., Rhode Island Department of Health, Rockefeller Institute for Medical Research, S. B. Penick & Company, Sloan-Kettering Institute, State of Connecticut, State Library Extension Service, United Fruit Company, United States Government, University of Pennsylvania Henry Phipps Institute, Veterans Administration, Western Section American Urological Association and Wyeth Laboratories.

During the past year, evening library hours were terminated, the reason being insufficient use by members. The library will, however, be open as usual on nights of meetings. The journals on the first floor of the stacks have been reshelfed to make room for new volumes. The librarian hopes to put the second floor in order this year which involves moving every volume there. The librarians of the medical and hospital libraries of Providence are working on a list of titles, showing the holdings of each library. This will facilitate the ever-expanding interlibrary loan system.

The Committee wishes to express its thanks to the ever-helpful library staff, Mrs. Helen DeJong and Miss Grace Dickerman.

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continued on page 472

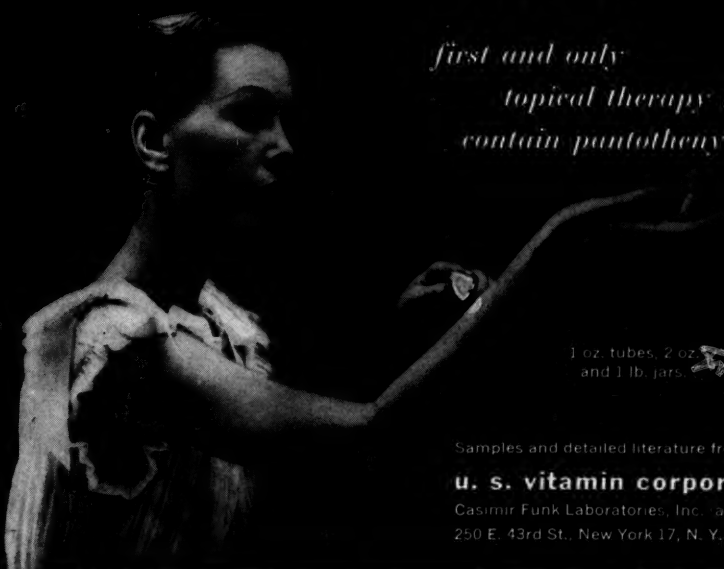
faster,
more effective,
safe relief from itching,
pain and irritation,
stimulation of granulation
and healing in
resistant eczema
dermatoses
pruritus
external ulcers
diaper rash
burns
ivy dermatitis
non-sensitizing

panthoderm cream

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topical therapy to
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and 1 lb. jars.

Samples and detailed literature from
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Casimir Funk Laboratories, Inc., affiliate
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ANNUAL REPORTS

continued from page 470

MEDICAL DEFENSE AND GRIEVANCE

This Committee has held necessary meetings through the year. Several malpractice cases were discussed and appropriate action taken. Grievance cases have increased in number and are usually due to a misunderstanding or are related to a financial problem. These cases are often simple of solution and require some investigation and a tactful reply to the aggrieved persons. In many instances, these complaints could be avoided if the physician would explain in detail to the patient the circumstances involved and also arrange the financial problem to the satisfaction of both parties. In one case, a hearing was held with the persons having a complaint and the doctor both present when a compromise settlement was effected. Fellows are urged to report promptly any case where a patient seems likely by his attitude to resort to legal measures for adjustment of a dispute or dissatisfaction with treatment even if the case has not been referred to a lawyer.

In view of the rising costs of malpractice insurance, every physician should review his coverage, and if in doubt, the amount of protection should be substantially increased.

ROLAND HAMMOND, M.D., *Chairman*
 CHARLES J. ASHWORTH, M.D.
 NATHAN A. BOLOTOW, M.D.
 GEORGE A. ECKERT, M.D.
 ADOLPH W. ECKSTEIN, M.D.
 HENRI E. GAUTHIER, M.D.
 THOMAS A. NESTOR, M.D.
 ALBERT H. JACKVONY, M.D.
 HENRY S. JOYCE, M.D.
 ROBERT G. MURPHY, M.D.
 PAUL J. VOTTA, M.D.
 ROBERT H. WHITMARSH, M.D.
 JOHN G. WALSH, M.D.
 HERMAN A. WINKLER, M.D.

NUTRITION

During the year the Nutrition Committee has maintained a liaison with 1) The Diabetic Committee, 2) The Nutrition Council of Rhode Island and 3) The State Nutritionist.

It has considered the matter of a group therapy obesity control program.

It has watched with interest the increasing use of margarine, skimmed milk powder and protein bread.

It has viewed with skepticism the low calory claims regarding a number of foods and beverages.

It has tried to keep abreast with scientific and popular nutritional developments.

WILLIAM L. LEET, M.D., *Chairman*
 F. BRUNO AGNELLI, M.D.

HARRY HECKER, M.D.
 ROBERT V. LEWIS, M.D.
 JAMES P. O'BRIEN, M.D.
 JOHN A. ROQUE, M.D.
 CLARA L. SMITH, M.D.
 MARK A. YESSIAN, M.D.

PUBLICATIONS

In 1951 the JOURNAL was beset with financial problems due to unexpected increases in the charges for printing the publication. By authority of the Committee and Editors the managing editor was assigned the task of reorganizing the advertising rate schedule, and expanding insofar as possible the volume of advertising.

The task was not an easy one. Our limited circulation, due to our small membership of physicians compared with larger states, affects the volume of advertising. Some agencies have a rule that they will not advertise unless a publication has a circulation of 2,000 or more. Others feel that Rhode Island is within the range of the NEW ENGLAND JOURNAL OF MEDICINE. Others prefer to concentrate on books issued by national medical societies and specialty groups.

Again, the increase in rates for advertising had to take into consideration the charges made by other journals with circulation figures comparable to ours.

However, a new rate schedule was finally drafted and made effective August 1, 1951. The results show in the 1952 report of receipts which represent a far more pleasant account to you than the 1951 final report which resulted in a loss of \$330.26 in our overall operations of the JOURNAL.

It is with much satisfaction that we report to you that in 1952 the JOURNAL showed a net profit.

While the increase in rates is primarily responsible for the present solvency of the JOURNAL, we also report that by friendly contact by the managing editor with various advertising agencies, many of whom are visited annually by him in New York, and by the cooperative action with the representatives of the pharmaceutical companies working in this area, we have built up much good will. As a result we have been favored with advertising contracts comparable to those given other state medical journals, and we have obtained several new accounts.

Suggested changes considered by the Committee include a new cover format for 1954 and further development of our editorial columns to make more effective the official pronouncements or opinions of the Society and of the Profession in general. The Committee has also requested that the executive secretary of the Society contribute at his discretion

continued on page 474

in the treatment of sick old people...



... to establish a more cooperative attitude in the "difficult" patient ... to relieve anxiety and irritability ... to overcome "confusion" and depression ... to revive interest in life and living ... to encourage activity and a sense of usefulness, prescribe ...

DEXAMYL* tablets and elixir

Each 'Dexamyl' tablet (or one teaspoonful of elixir) contains Dexedrine* Sulfate (dextro-amphetamine sulfate, S.K.F.), 5 mg., and amobarbital (Lilly), 1/2 gr.

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off.

ANNUAL REPORTS

continued from page 472

the column carried some years ago under the caption, "Through the Microscope."

JOHN E. DONLEY, M.D., *Chairman*
 IRVING A. BECK, M.D.
 HERBERT FANGER, M.D.
 CHARLES L. FARRELL, M.D.
 RUSSELL P. HAGER, M.D.
 WILLIAM J. MACDONALD, M.D.
 WILFRED PICKLES, M.D.
 JOSE M. RAMOS, M.D.
 ROBERT W. RIEMER, M.D.

PUBLIC LAWS

The committee on public laws held several meetings during the time the General Assembly was in session, and devoted much time to the proposals for amendments to the state workmen's compensation law. At the request of the House of Delegates the committee actively participated in hearings and conferences with Assembly committees and representatives of the Governor in an effort to resolve differences of opinion regarding this particular legislation. The committee reports with regret that all efforts to improve the medical phases of the law, including the proposed amendments drafted by the House of Delegates and introduced in the Assembly for the Society, proved of no avail. It is to be hoped that this legislation may win support at the next session of the Assembly.

Legislation enacted having a bearing on health and welfare included the following:

Narcotic Drugs. A tightening of the regulations for the sale of narcotic drugs to minors, and providing stiff penalties for conviction in such sales.

Physician's Residence on Block Island. Permission for the Town of New Shoreham to provide a home for a resident physician on Block Island.

Ice Cream Standards. New definitions and standards of identity for ice cream, frozen custard, ice

RHODE ISLAND MEDICAL JOURNAL

milk, sherbet and water ice, to prevent confusion, fraud and deception in connection with the sale of such products.

Medical Examiners. Addition of several new medical examiners in Rhode Island, with seven county examiners to serve the counties of Providence and Bristol, one of whom shall be a resident of Bristol, four for the county of Newport, one a resident of New Shoreham, and one a resident of Portsmouth, Tiverton or Little Compton; three for the County of Washington, one of whom shall reside in Westerly, and two for the county of Kent.

Regulations for Homes to Aged, Blind, Convalescent. Institutions providing care or service to aged, blind, disabled or convalescent persons not previously subject to the complete licensing regulations shall now be subject to rules and regulations of the department of social welfare encompassing the health, safety, and humane treatment of the residents of said institutions. Such regulations will have the full force and effect of law.

Special Auto Parking Privileges. Henceforth no city or town shall exact a parking fee from any person who, by reason of the amputation of one or both of his arms or legs as a consequence of paralysis, arthritis or other permanent injury, and who owns a pleasure motor vehicle operated for his pleasure and convenience upon which there is displayed such special registration plates as shall be issued by the registry of motor vehicles.

Money for Hospitals. To reimburse partially general hospitals for expenses incurred in maintaining facilities for the care of citizens the sum of \$137,700 was given Rhode Island hospital, \$82,100, Newport hospital, \$30,900, Miriam hospital, and \$32,000, Pawtucket Memorial.

Commission on Public Health Services. The Governor was authorized to appoint a 9-member commission to study methods for improving public health services and decentralizing the present public health setup in Rhode Island.

Legislation Not Enacted. Legislative acts proposed but either left in committee or passed by one or the other branches of the Assembly and then referred to committee to die, included the following proposals:

Several amendments to the workmen's compensation law (including one proposed by the R. I. Medical Society); permissive legislation for the administrator of the temporary disability program to make known to a committee of the R. I. Medical Society complete data to aid him to adjudicate a claim for benefits; amendments to the law regulating the practice of optometry; a resolution for a commission to study and report on the feasibility of a medical school at the University of Rhode

continued on page 476

Butterfield's DRUG STORE

Corner Chalkstone & Academy Aves.

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IN SUMMER ALLERGIES...

*transform discomfort
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Such a transformation initiated by Neo-Antergan enables many allergy patients to live comfortably through difficult Summer months when pollen levels soar.

By effectively blocking histamine receptors, Neo-Antergan brings significant symptomatic relief with a minimum of undesirable physiologic effects.

Promoted exclusively to the profession, Neo-Antergan is available only on your prescription.

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The Physician's Product

Neo-Antergan[®]

MALEATE
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COUNCIL  ACCEPTED

*Research and Production
for the Nation's Health*



MERCK & CO., INC.

Manufacturing Chemists

RAHWAY, NEW JERSEY

ANNUAL REPORTS

continued from page 474

Island; a bill relative to the regulation of dental laboratories; a study commission on the state employment security and disability compensation programs; an amendment weakening the basic science law; a proposal that physicians report cases of epilepsy to the registry of motor vehicles.

Vetoed by the Governor. A bill passed by the Assembly that would extend veterans relief benefits to 1800 gold star mothers, including reasonable hospital and medical care, was vetoed by the Governor.

JAMES H. FAGAN, M.D., *Chairman*
 ARTHUR RATTENI, M.D.
 HERBERT E. HARRIS, M.D.
 EDWARD H. TRAINOR, M.D.
 JEAN MAYNARD, M.D.
 F. BRUNO AGNELLI, M.D.
 THOMAS LALOR, M.D.
 ROBERT V. LEWIS, M.D.
 EDWARD A. McLAUGHLIN, M.D.

PUBLIC POLICY AND RELATIONS

The Committee has been actively engaged in efforts to improve the public relations of the Medical Society, especially in the matter of the handling by the press of medical and Medical Society news. In this connection several discussions have been held with important members of the press. A formal medical-press conference was held in December at which time the Committee and various officials of our Society met with newspaper editors and publishers of the state. Your Committee presented a proposed code of cooperation to the representatives of the press and asked for their help in drawing up a code to which our Society and the Press might be willing to subscribe.

As a result of the conference and discussions which have followed it your Committee has drawn up a code of cooperation by the physicians and the press and radio in Rhode Island and hereby presents to the Council with recommendations for its adoption the obligations of the Medical Society under this code. It is hoped that the Press will observe on its part the following articles of cooperation.

Your Committee attended a conference with members of the State Department of Economic Security to discuss matters of mutual interest.

Your Committee has reinstituted the publication of "RIMSCOPE." Your Committee considers "RIMSCOPE" a valuable means of communicating to the members of the Society matters concerning public policy and relations.

CLIFTON B. LEECH, M.D., *Chairman*
 DONALD L. DENYSE, M.D.
 JOHN F. W. GILMAN, M.D.
 M. OSMOND GRIMES, M.D.

RHODE ISLAND MEDICAL JOURNAL

CHARLES L. FARRELL, M.D.
 FRANCIS J. KING, M.D.
 EARL J. MARA, M.D.
 ARNOLD PORTER, M.D.
 H. FREDERICK STEPHENS, M.D.

SCIENTIFIC WORK AND ANNUAL MEETING

This committee has held several meetings throughout the year, a good deal of the ground-work having been accomplished immediately after the annual meeting last May. Only due to unexpected cancellations of a few previously committed speakers was the completion of the final program delayed until very recently. I am sure the committee shares my enthusiasm for the program that has been arranged and its diversification to make this one of the largest attended annual meetings the Society has ever held.

My sincere thanks are extended to all the members of the committee for their conscientious interest and individual effort in completing the arrangements.

CHARLES J. ASHWORTH, M.D., *Chairman*
 JOHN T. BARRETT, M.D.
 J. MURRAY BEARDSLEY, M.D.
 WILFRED I. CARNEY, M.D.
 MORGAN CUTTS, M.D.
 MARSHALL FULTON, M.D.
 EDWIN B. GAMMELL, M.D.
 WILLIAM HINDLE, M.D.
 LOUIS I. KRAMER, M.D.

SOCIAL WELFARE

Your Committee on Social Welfare has been actively concerned with Medical Pool plans of the Department of Public Welfare throughout the year.

The Medical Pool plan was instituted on July 1, 1952 and during the year problems arising from the plan have been discussed with Dr. P. Joseph Pesare, Medical Director of the plan.

As the varied problems were presented by practicing physicians, the chief complaints were 1) The delay in payments for services rendered, 2) The great amount of paper work involved.

These problems were placed before Dr. Pesare on several occasions and it has been our opinion that he has tried diligently to speed up payments to physicians but that a great backlog still exists. As to the paper work involved, there have been slight changes in procedure, but it is our opinion that clerical work on the physicians' side can be and should be greatly reduced.

The Medical Pool plan statistics are available only from July 1 to November 30, 1952 for Federally aided categories, and from July 1, 1952 to December 31 for General Public assistance cases.

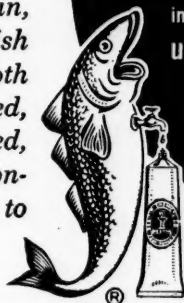
Statistics submitted to the Chairman of your

continued on page 478



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Tubes of 1 oz., 2 oz., 4 oz., and 1 lb. jars.

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70 Ship Street • Providence 2, R. I.

1. Behrman, H. T., Combes, F. C., Bobroff, A., Leviticus, R.: Ind. Med. & Surg. 18:512, 1949.
2. Turell, R.: New York St. J. M. 50:2282, 1950.
3. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives Pediat. 68:382, 1951.

ANNUAL REPORTS

continued from page 476

Committee were received only yesterday and consequently have not been available to the full committee for study. However, these statistics have been awaited by many physicians and are therefore appended to this report for your perusal.

Dr. Pesare states that it is difficult to break down the expenditures into a per-capita basis by category because of 1) The fluctuating case load, 2) The outstanding bills, 3) The months of normally low sickness rate, 4) The varying incidents of morbidity during different months, 5) The limited period of study.

It has been stated that more time must elapse and more experience be gained before a complete appraisal of the program can be made. Your committee goes along with this thinking at the moment, but is ever watchful of the details submitted to it.

An attempt to break down the cost of hospital care for welfare patients will be made, so that we may have an idea of the value of Physicians Services given free to hospitalized welfare recipients. Your chairman believes the value of such a study will show that free services rendered by physicians to welfare recipients in hospitals will be over 200% of the amount actually paid to physicians for home and office care involving these same recipients. It is further noted that such payments are below the scale approved by the Rhode Island Medical Society for governmental agencies.

These studies should offer definite evidence that no segment of society gives so much for so little, to the unfortunate and underprivileged than the physicians of Rhode Island. Exhibits will show approximately 10% of health expenditures were paid to physicians.

Our thanks go to Dr. Pesare for his cooperation in attending the meetings and submission of pertinent data.

It is refreshing, to say the least, to deal with one's colleague in matters of this nature, after so many years of working with those trained in fields quite remote from our own. Our thanks to members of the Society for bringing their problems to us, so that they might be discussed with a resultant benefit to all.

EARL J. MARA, M.D., *Chairman*

PETER F. HARRINGTON, M.D.

ANTHONY CORVESE, M.D.

SOLOMON L. FRUMSON, M.D.

HENRY S. JOYCE, M.D.

THOMAS H. MURPHY, M.D.

HAROLD W. WILLIAMS, M.D.

MARK A. YESSIAN, M.D.

WALTER E. CAMPBELL, M.D.

Medical Pool Expenditures

Distribution of bills for the categorical cases from
July 1st to November 30th, 1952.

(Exclusive of General Public Assistance)

Hospitalization, ambulance fees, etc.	\$206,263.99
Drugs	40,355.28
Medical Doctors	37,021.21
Dentists	41,967.25
Opticians	6,509.48
Chiropodists	499.22
Misc. Medical Service	670.70
	<hr/> \$333,287.13

Figures are not available on a monthly basis as we are still receiving bills dated back three or four months.

Medical Pool Assessments

OAA	\$9 per person
AB	9 per person
AD	9 per person
ADC	12 per case

Vendor Payments for Medical and Remedial Care Classified by Type of Service and Category of Eligible Recipient

	Total	Practitioners Services	Hospital- ization	Drugs and Supplies	Other
Total—all programs—Note 1 and 2 below	\$549,962.76	\$60,024.51	\$366,895.30	\$51,444.48	\$71,598.47
a. Old Age Assistance	206,196.38	30,993.06	129,142.69	29,406.29	16,654.34
b. Aid to Dependent Children	108,851.73	11,415.65	66,438.58	8,246.49	22,751.01
c. Aid to the Blind	5,126.05	276.76	3,497.96	526.09	825.24
d. Aid to Disabled	13,112.97	2,015.14	7,184.76	2,176.41	1,736.66
e. General Public Assistance	216,675.63	15,323.90	160,631.31	11,089.20	29,631.22
<i>Percentage Distribution</i>					
Old Age Assistance	37.5%	51.6%	35.2%	57.2%	23.2%
Aid to Dependent Children	19.8	19.0	18.1	16.0	31.8
Aid to the Blind	0.9	.5	1.0	1.0	1.2
Aid to Disabled	2.4	3.4	2.0	4.2	2.4
General Public Assistance	39.4	25.5	43.7	21.6	41.4
Total	100.0%	100.0%	100.0%	100.0%	100.0%
All Programs	100.0%	10.9%	66.7%	9.4%	13.0%

Note—these expenditures represent

- 1) 5 months' bills from pooled fund for federally-aided categories
- 2) 6 months' payments from General Public Assistance